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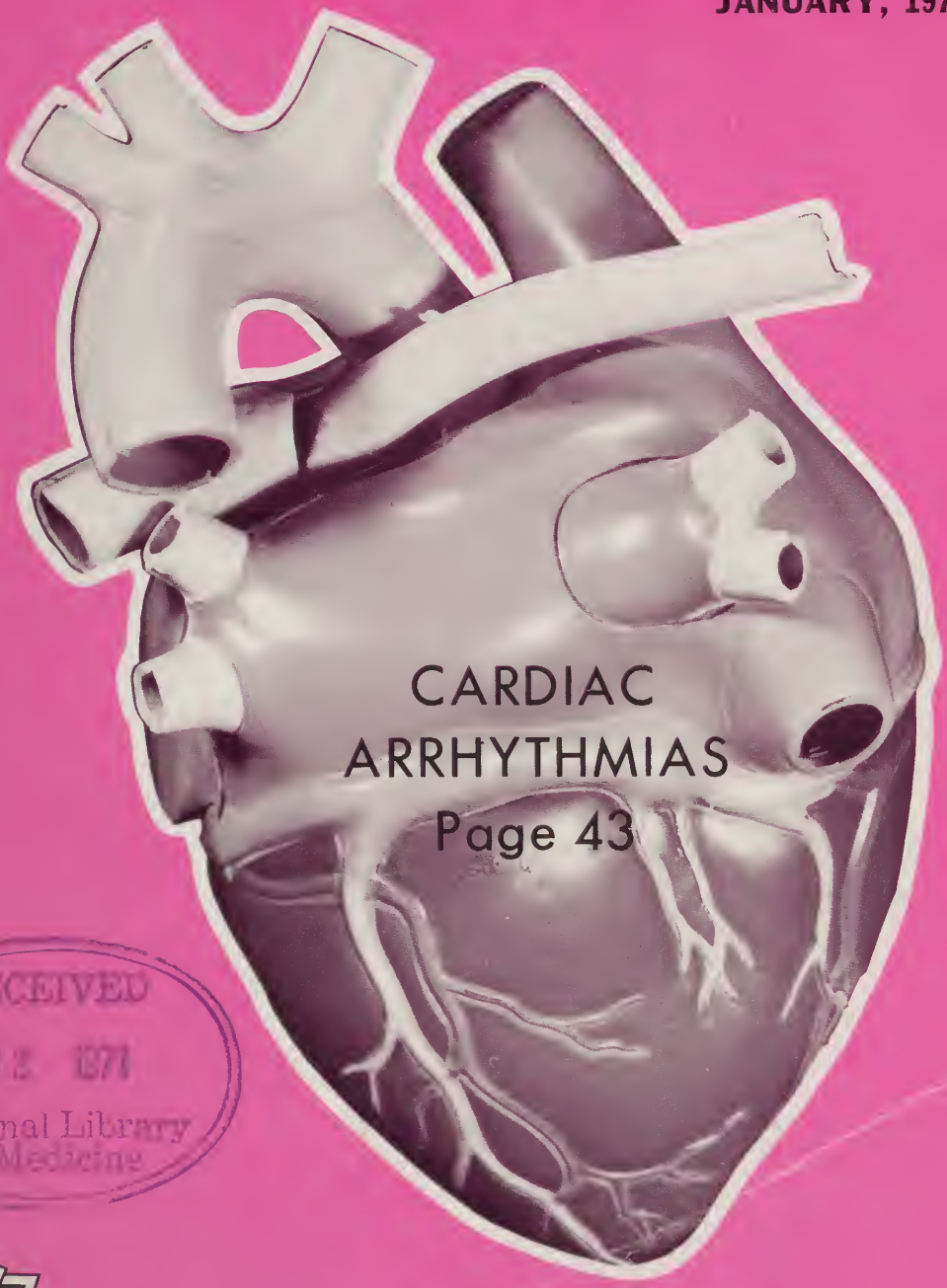
PENNSYLVANIA MEDICINE

JANUARY, 1971



CARDIAC ARRHYTHMIAS

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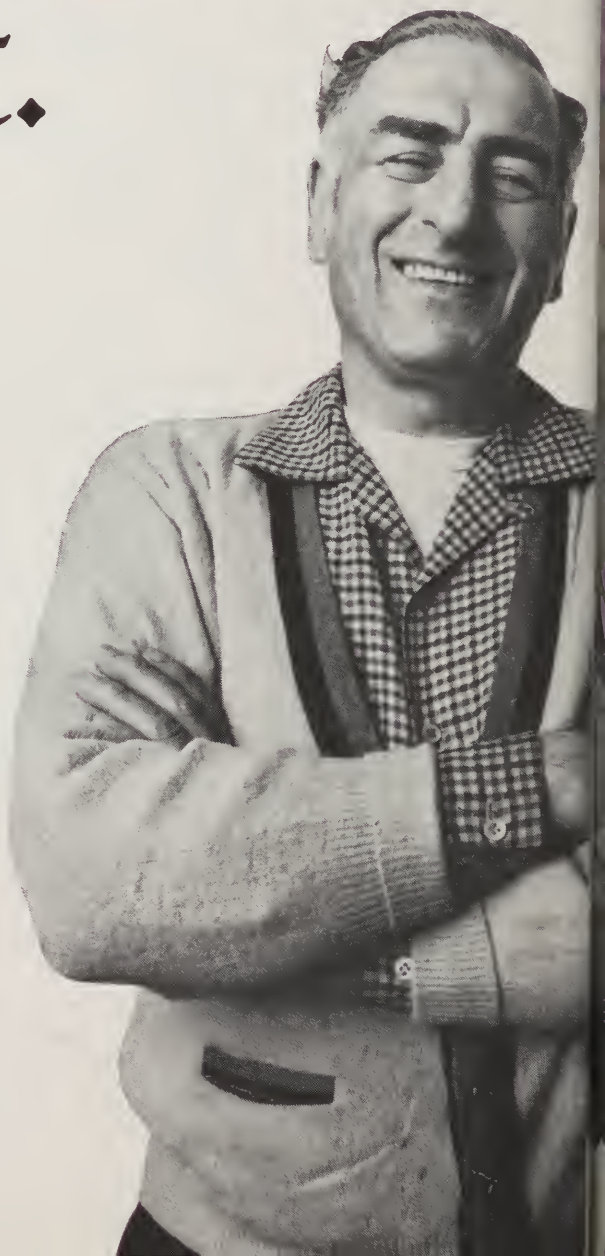
Menrium® treats the menopausal symptoms that bother him most.



Roche
LABORATORIES
Division of Hoffmann La Roche Inc.
Nutley, New Jersey 07110

His wife has a lot of different menopausal symptoms, but only a few really irritate *him*. Her hot flashes, her vertigo, her palpitations—that's *her* problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed as endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

Menrium takes care of hot flashes, vertigo, palpitations in most menopausal women. Menrium provides the well-known antianxiety action of chlordiazepoxide (Librium®) and water-soluble esterified estrogens. It therefore relieves more symptoms than either component separately. It takes care of the vasomotor symptoms as well as the emotional symptoms. This means the symptoms that bother his wife most. And the symptoms that irritate him most.

So, to help them both get through her menopause, remember Menrium.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens

PENNSYLVANIA MEDICINE

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Journal of the Pennsylvania Medical Society

JANUARY, 1971 VOLUME 74, NUMBER 1

PENNSYLVANIA MEDICINE
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ctrolyte imbalance may occur when using diuretics. Hygroton is contraindicated in severe renal or hepatic diseases and, of rse, if it causes hypersensitivity. Carefully supervise those who may be receiving other antihypertensives.

groton® chlorthalidone USP *Indications:* Hypertension and many types of edema involving retention of salt and water. *Contraindications:* persensitivity and most cases of severe renal or hepatic diseases. *Warnings:* With the administration of enteric-coated potassium supplements, which uld be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and foration) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium plements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant women and sing mothers since the drug crosses the placental barrier and appears in cord blood and since thiazides appear in breast milk. The drug may result etal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of dbearing age, balance benefits of drug against possible hazards to fetus. *Precautions:* Antihypertensive therapy with this drug should always be iated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. luce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic rmination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte alance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and assium supplements given, provided the patient does not have marked oliguria. Take special care in cirrhosis or severe ischemic heart disease and in ents receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. *Adverse Reactions:* Nausea, gastric irritation, vomiting, rexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic otension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, mbocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and creatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of mpounds include: jaundice, xanthopsia, paresthesia, and photosensitization. *Average Dosage:* 50 or 100 mg. with breakfast daily or 100 mg. every other . *How Supplied:* White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000. (B)46-230-G *For full details, please the complete prescribing information.*

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Guide his hand to quality and economy

Specify Deltasone® 5 mg. (prednisone, Upjohn)

an economical prednisone that's made a name for itself

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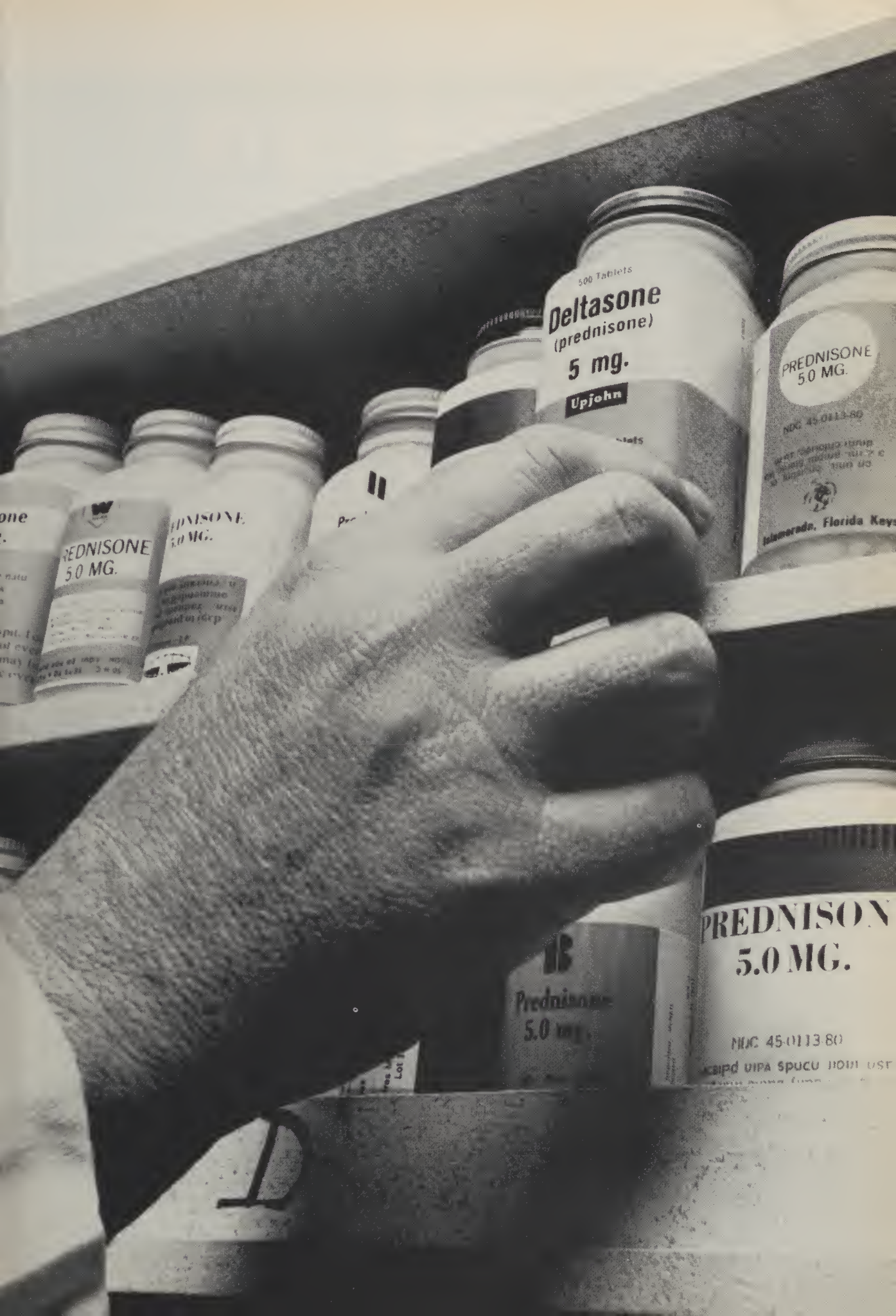
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Deltasone
(prednisone)
5 mg.
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5.0 MG.
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DELTASONE® TABLETS—2.5 & 5 mg.
(prednisone, Upjohn)

The potency of prednisone exceeds cortisone in glucocorticoid and anti-inflammatory activity by about five times on a weight basis, but is considerably less active than cortisone in mineralocorticoid activity.

Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. *Important:* Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptomatically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9-alpha-fluro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoids during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis, an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and, whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

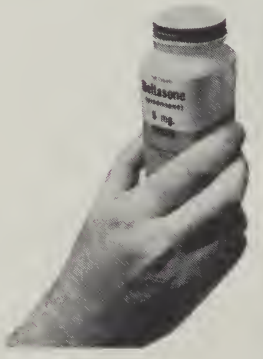
Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angiitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

Supplied: 2.5 mg., scored—bottles of 100 tablets. 5 mg., scored—bottles of 100 and 500 tablets and cartons of 100 tablets in foil strips.

For additional product information, consult the package insert or see your Upjohn representative.

MED B-1S (KQ

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001



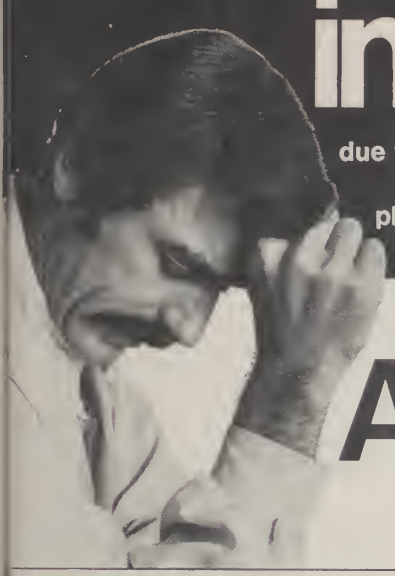
Deltasone® 5 mg. (prednisone, Upjohn

an economical prednisone that's made a name for itself

The treatment of

impotence

due to androgenic deficiency in the American male. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.



NEW CLINICAL STUDY

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients—Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society

Android®

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Double-Blind Study and Type of Patient:
100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android	Android-HP (HIGH POTENCY)	Android-X (EXTRA HIGH POTENCY)	Android-Plus (WITH HIGH POTENCY B-COMPLEX AND VITAMIN C)
Each yellow tablet contains:	*Each red tablet contains:*	*Each orange tablet contains:*	*Each white tablet contains:*
Methyl Testosterone ..2.5 mg.	Methyl Testosterone ..5.0 mg.	Methyl Testosterone .12.5 mg.	Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.	Thyroid Ext. (½ gr.) ...30 mg.	Thyroid Ext. (1 gr.) ....64 mg.	Thyroid Ext. (¼ gr.) ...15 mg.
Glutamic Acid .....50 mg.	Glutamic Acid .....50 mg.	Glutamic Acid .....50 mg.	Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....10 mg.	Thiamine HCL .....10 mg.	Thiamine HCL .....10 mg.	Thiamine HCL .....25 mg.
Dose: 1 tablet 3 times daily.	*Dose:* 1 tablet 3 times daily.	*Dose:* 1 or 2 tablets daily.	Glutamic Acid .....100 mg.
Available:	*Available:*	*Available:*	Pyridoxine HCL .....5 mg.
Bottles of 100, 500, 1000.	Bottles of 100, 500, 1000.	Bottles of 60, 500.	Niacinamide .....75 mg.
			Calcium Pantothenate .10 mg.
			Vitamin B-12 .....2.5 mcg.
			Riboflavin .....5 mg.
			Dose: 2 tablets daily.
			Available: Bottles of 60, 500.

REFER TO PDR

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. **2. Dublin,** M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. **3. Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. **4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. **5. Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. **6. Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. **7. Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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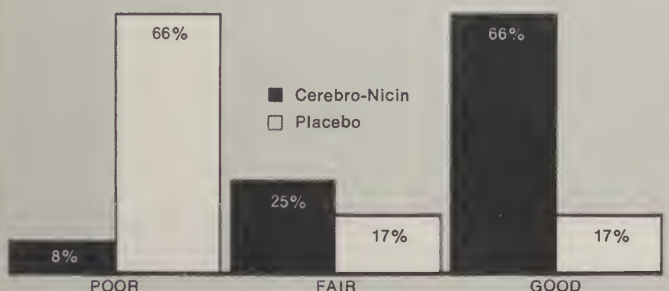
For the treatment of the aging patient

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
1-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir 8 oz. bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

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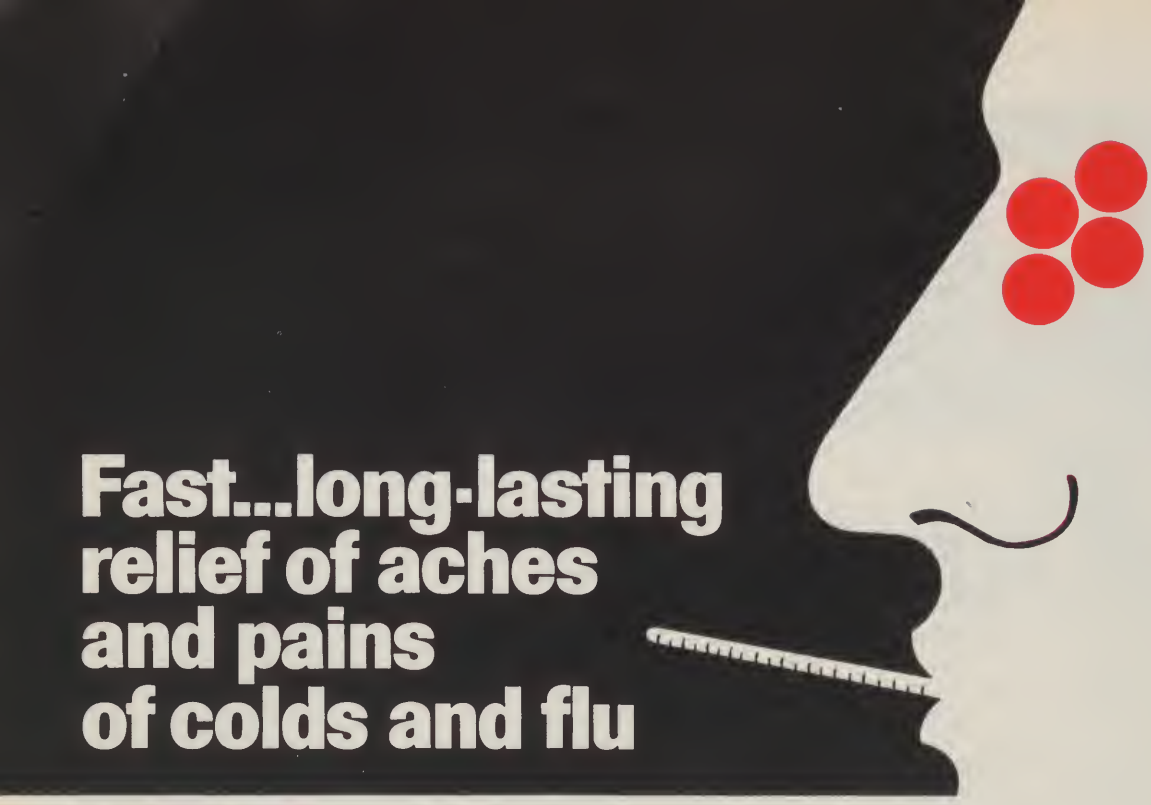

Fast...long-lasting relief of aches and pains of colds and flu

with the unique timed-release aspirin

Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

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MEASURIN®
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ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF

Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.

Available: Bottles of 12, 36 and 60 tablets.

PMS COMMITTEE MEETS WITH MED SCHOOL DEANS

A committee of the PMS Board of Trustees met in December with the deans of Pennsylvania's medical schools, or their representatives, to discuss requirements for producing more physicians. Formal liaison was established. Several proposals discussed at the session will be presented to the Board of Trustees for consideration.

STATE RENAL DISEASE COMMITTEE HOPES TO BEGIN PROCESSING APPLICATIONS SOON

Members of the State Renal Disease Advisory Committee met in December to begin implementing Act No. 140 of the State Legislature by establishing standards for expenditure of funds, to assure the availability of specialized personnel, resources and equipment necessary to enable such persons to function, and to care for persons with severe uremia. The committee also is responsible for evaluating the qualifications of institutions providing care for patients with chronic renal disease. Chairman of the committee, George Bender, M.D., director of the Chester County Health Department, expressed the hope that the Department of Health would be able to process applications for funds in the near future. A target date of Feb. 28, 1971, has been established by the committee.

AMA RURAL HEALTH MEETING SCHEDULED FOR ATLANTA

The twenty-fourth national conference on rural health will be held March 26 and 26, 1971, at the Marriott Motor Hotel, Atlanta, Ga. Conference goals are to discuss methods of health services delivery in rural areas, to develop planning methods for community organization for health services and to review efficient utilization of health services.

PMS OFFICERS' CONFERENCE SCHEDULED FOR APRIL

Topics vital to every Pennsylvania physician are part of the 1971 Officers' Conference of the State Society to be held April 28 and 29 at the Penn Harris Motor Inn in Camp Hill. They include such things as discussions of the proposed Pennsylvania Medical Care Foundation-- a prepaid, closed panel medical care program on a statewide basis to meet federal and other pressures for such a concept, and a panel on the details of the continuing education requirements for State Society membership as voted by the 1970 House of Delegates.

NEW MEDICAID REGULATIONS PROVIDE SCREENING FOR YOUNG

Individuals under twenty-one who are eligible for Medicaid will be screened and treated under new rules announced by the Department of Health, Education and Welfare. States are responsible for comprehensive planning necessary for the plan, which, if resources

are limited, is to begin with children under six, extending to others in stages so that all are covered by July 1, 1973.

JANUARY DESIGNATED "BLOOD DONOR MONTH"

President Nixon has proclaimed January as "National Blood Donor Month, to honor the voluntary blood donors and to encourage increasing numbers of people to be voluntary blood donors." John B. Henry, M.D., president of the American Association of Blood Banks, said: "U. S. hospitals now use 6,500,000 pints of blood a year. If only a few more Americans will donate a pint of blood during the month, shortages which often mark January will not be repeated."

STATE ANNOUNCES METHADONE USE RULES

The State Drug, Device and Cosmetic Board has announced tentative rules governing the use of methadone in approved addict "maintenance" clinics and for withdrawal progams in institutions. They are subject to review by the attorney general before becoming effective and at least one of the provisions would require a waiver from the U.S. Food and Drug Administration. The provision in conflict with FDA regulations would permit addicts under 18 to be maintained at approved clinics. The state seeks the waiver because facilities for detoxification are not adequate to handle all of the state's addicts. It is illegal for a physician to use any narcotic in his office for either detoxification or maintenance. Detoxification is limited to institutions and maintenance to state-approved programs. Complete rules will be announced as soon as they become available. Meanwhile, the Dept. of Public Welfare announced that physicians and pharmacists would be dropped from the Medicaid program if they improperly supplied narcotics including methadone to addicts.

PMS COUNCIL HELPS TO CLEAR WAY FOR SAMA PRECEPTORSHIP PLAN

The Medical Education and Community Orientation (MECO) project of the Student American Medical Association which has the support of the AMA and of the State Society, is expected to be put to use in Pennsylvania through the help of the PMS Council on Education and Science and the Hospital Association of Pennsylvania. The SAMA-MECO project will give medical students an opportunity for on-the-job training in communities throughout the Commonwealth. They will work with local doctors and in community hospitals during school vacation periods. The AMA House of Delegates passed a resolution at its recent clinical convention stating it "strongly supports the principle of the SAMA-MECO project as an adjunct to undergraduate medical education."

CONGRESS PASSES TWO MAJOR BILLS

Prior to its final adjournment, the ninety-first Congress passed the occupational health and safety bill, which establishes a commission to establish and enforce federal health and safety standards in industry, and the family practice bill which will provide funds for medical schools to establish departments of family medicine.

Conference Studies Treatment Of Alcoholics

There are two kinds of alcoholics. One "can't stop drinking once they start...even if it's months between starts." The other "can't feel normal without alcohol, even just a little." The definitions came from Abraham J. Twerski, M.D., clinical director of St. Francis General Hospital in Pittsburgh. He made the remarks during a two-day conference on "Hospital Care of the Alcoholic," held in Harrisburg in December. Sponsors of the meeting were the Hospital Association of Pennsylvania, the Pennsylvania Psychiatric Society and PMS.

The conference, attended by over 150 hospital administrators, physicians, nurses, social workers, and chaplains, was made possible by a grant to the American Hospital Association from the National Institute of Mental Health, National Center for Prevention and Control of Alcoholism. It was the first of a series of such programs being conducted throughout the nation.

Featured speakers on the program included: Marvin A. Block, M.D., State University of New York Medical School; Mark Berke, president of the American Hospital Association, San Francisco; Ronald J. Catanzaro, M.D., director of the Palm Beach Institute, Florida; Pauline Cohen, project director of Family Service Association of America, New York; and Donald J. Ottenberg, M.D., medical director of Eagleville Hospital and Rehabilitation Center, Eagleville, Pa.

In his keynote address Dr. Block, chairman of the AMA Committee on Alcoholism called it the fourth greatest public health problem in the nation. "It is estimated that there are between six and eight million alcoholics in this country, and I consider this a very conservative estimate. If we were to take into account the early alcoholic I think there would be at least twice that many.

"Alcoholism is brought about by a multiplicity of factors. The causes may be psychological, chemical, metabolic or any number of other reasons. Certainly alcohol cannot be considered the only cause of alcoholism...It isn't the causative agent which is the cause of the disease, but rather the individual who uses it...Recovery for the

PRACTICAL METHODS of treatment and detoxification of alcoholic patients were discussed in depth at a recent conference on "Hospital Care of the Alcoholic," held in Camp Hill, Pa. Over 150 conferees from throughout the Commonwealth attended the sessions. Shown above are activities in the workshops.

Conference Studies Treatment

alcoholic means total and permanent abstinence.

"When the medical community leads the way in education so that we can apply the knowledge we now have, only then can we make inroads on this, our fourth greatest national health problem."

The two-day conference considered the problems of admitting alcoholics to general hospitals, the use of established treatment groups, and using community resources in solving the problem. The final address of the conference was given by Dr. Ottenberg.

Pennsylvanians serving on a resource panel included Dr. Twerski; Barbara J. Driscoll, R.N., St. Vincent Hospital Association, Erie; and John C. Webber; director of the Health and Welfare Council, Norristown.

Other members of the conference faculty were J. Winstead Adams, Eagleville Hospital and Rehabilitation Center, Eagleville; LeRoy C. Erickson, Pennsylvania Medical Society, Lemoyne; Robert Fishman, Resources for Human Development, Inc., Wynnewood; William Gaennor, Altoona Hospital; John P. Kleman, United Mental Health Services of Allegheny County, Inc., Pittsburgh; Mrs. Thelma Sandy, R.N., Uniontown Hospital; Miss Margaret Sutton, Department of Health; Stephen Tucker, Harrisburg Hospital; Edward J. Waldman, Jr., Mercy Hospital, Pittsburgh; and Miss Marian J. Wettrick, Department of Public Welfare.

Self Testing Program Available To M.D.'s

The American College of Physicians (ACP) has announced the introduction of its second medical knowledge self-assessment program. The program consists of 700 questions in nine different areas of general medicine, and is available to all physicians.

Designed to help physicians determine the current level of their biomedical knowledge, the program points out areas which should be explored in the future. The test is not one for testing clinical competence.

Areas included in this program are hematology, rheumatology, neurology, pulmonary disease, infectious disease and allergy, gastroenterology, renal disease and electrolytes, endocrinology and metabolic disease, and cardiovascular disease.

Physicians desiring a prospectus may obtain one by writing to the American College of Physicians, Box MKSAP - II, 4200 Pine St., Philadelphia, 19104. Cost of participation for ACP members is $20, for non-members $40.

VA Drug Centers Open This Month

Five drug treatment centers are being opened by the Veterans Administration this January. The centers, located in California, New York, Michigan, Texas and Washington, D.C., are geared to provide treatment for 6,000 veterans who are drug dependent.

Donald A. Johnson, administrator of Veterans Affairs, says thirty such centers can be in operation by 1973.

Philadelphia M.D. To Head National Radiology Society

Herbert M. Stauffer, M.D., Philadelphia, has been named president-elect of the Radiological Society of North America (RSNA) at its 56th annual scientific assembly in Chicago.

Dr. Stauffer, of Temple University Hospital, will assume the presidency when the 5,000-member society meets in Chicago November 28-December 3, 1971. The RSNA is the largest scientific radiological organization in North America.

More than 3,500 physicians met in Chicago to hear 200 papers on new developments in all areas of radiology and to attend daily refresher courses. Total registration was nearly 8,000.

$ Million Grant Won By St. Christopher's

A renewed three-year grant for over $1 million has been awarded to the clinical research center of St. Christopher's Hospital for Children in Philadelphia.

The center, opened in 1963, is a multidisciplinary research facility operating under the direction of Angelo M. DiGeorge, M.D. The eight-bed unit has pioneered in the study of such disorders as phenylalanemia, cystic fibrosis of the pancreas and degenerative nervous system disorders. Dr. DiGeorge headed the team that first detected the congenital absence of thymus and studied immunologic deficiency in humans.

Diabetes Screening Aids Early Detection

The Pennsylvania Department of Health screened over 176,000 Pennsylvanians for diabetes in the twelve-month period ending June 30, 1970. Of the people screened some 1,478 were found to have symptoms of diabetes and were referred to their physicians for tests and treatment.

The program was directed at early detection of diabetes among adults, in whom the symptoms are often so vague that they are ignored until an emergency occurs. Early detection leads to control of the disease.

Cancer Committee Officers Elected

The Pennsylvania Cancer Coordinating Committee held elections at its recent annual meeting. Officers for 1971 include Charles A. Waltman, M.D., Easton, as chairman, and Hugh R. Gilmore, M.D., Harrisburg, as secretary.

This year the committee, composed of representatives from the Pennsylvania and Philadelphia Division of the American Cancer Society, the Pennsylvania Medical Society, the Pennsylvania Dental and Osteopathic Associations, the Pennsylvania Department of Health and the Wainwright Tumor Clinic Association, will work to have restored the recent cuts in federal appropriations for cancer programs, to increase the number of women having annual Pap smears, to reduce the use of cigarettes, and to improve the treatment and diagnosis of cancer.

Hahnemann Expands As Result Of Deed

The Physicians and Surgeons Hospital, Philadelphia, has been deeded to Hahnemann Medical College and Hospital of Philadelphia. George D. Dragone, president of the hospital made the gift to Hahnemann in recognition of Hahnemann's role in developing the Spring Garden Community Services Center to serve the disadvantaged residents of the city.

Plans are now being made for the utilization of the five buildings which comprise the hospital.

Fellowship Requirements Relaxed At Session

Fellowship requirements of the American College of Preventive Medicine, heretofore limited to those certified by the American Board of Preventive Medicine, have been expanded to admit physicians engaged full time in practice, teaching or research in the field of preventive medicine who are board certified in areas other than preventive medicine.

A bylaws amendment affecting the change was approved unanimously at the College's Seventeenth Annual Meeting in Houston October 29, 1970.

President Katherine Boucot Sturgis, M.D., of Philadelphia, announcing the change, said, "This will greatly broaden the scope of the college fellowship, especially in academic circles where many physicians board certified in such fields as pediatrics and internal medicine have lifted their horizons to appreciate the need to prevent illness, promote health and apply the results of research."

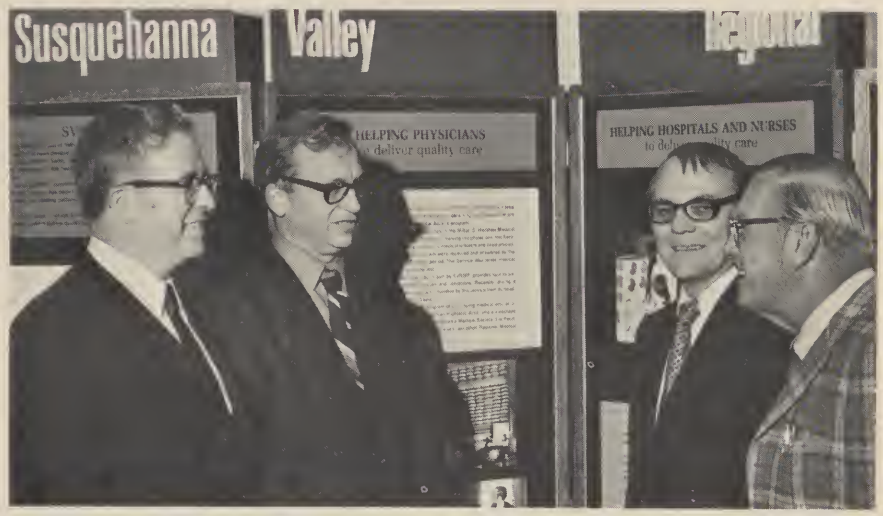
New officers of the college installed at the meeting are: President William P. Richardson, M.D., Chapel Hill, N.C., succeeding Katherine Boucot Sturgis, M.D., Wynnewood; President-Elect Lee B. Grant, M.D., Pittsburgh; Vice-Presidents Vlado A. Getting, M.D., Ann Arbor, Mich.; Col. George R. Anderson, USAF, MC, Randolph AFB, Texas; Thomas S. Ely, M.D., Rochester, N.Y.; J. Thomas Grayston, M.D., Seattle, Wash.; and Secretary-Treasurer Bernard Behrend, M.D., Philadelphia.

Library Of Medicine Gets Surgical Films

The American College of Surgeons (ACS) and the surgical suture firm of Davis & Geck (D&G) collaborated on the production of twenty-two motion picture films showing outstanding surgical advances of the past twenty years. The films were donated to the National Library of Medicine, National Institutes of Health, Bethesda, Md.

The presentation marked the twentieth anniversary of the ACS/D&G "Cine Clinic" program.

Among the noted physicians included in the films were Frank H. Lahey, M.D., founder of the Lahey Clinic; Michael E. DeBakey, M.D., pioneer heart surgeon; and the late Richard B. Cattell, M.D., who headed the Lahey Clinic and first suggested the ACS/D&G "Cine Clinic" program.



AMONG THE MEMBERS of the newly-formed Council on Education and Manpower of the Susquehanna Valley Regional Medical Program are, from left, Thomas F. Fletcher, M.D., Harrisburg Hospital; David A. Smith, M.D., Harrisburg Polyclinic Hospital; Franklin E. Williams, SVRMP's Educational Coordinator; and Charles M. Worrell, D.O., Community General Osteopathic Hospital, Harrisburg. The council's goal is the improvement of patient care throughout central Pennsylvania through the exploration of community hospital programs. The group will evaluate medical care, continuing medical education programs and study the ways of improving manpower utilization within the region, as well as continue the development of a computerized system for collecting information on outpatient health care.

PSU Professor To Study Ways To Evaluate Ear Protectors

Paul L. Michael, Ph.D., a professor of environmental audiology at Pennsylvania State University has found that noise from heavy industry, rock music and power mowers is generated at a high enough level to impair the hearing of half of America's workers over a period of years.

Although the figure sounds high it represents the consensus of opinion of hearing specialists. In an effort to combat this noise pollution problem Dr. Michael has been presented with a grant from the U. S. Public Health Service to develop an objective method of evaluating ear protectors.

Dr. Michael pointed out that one of the problems encountered is that there is no good way to find out which people are susceptible to noise pollution and so everyone must be protected against possible permanent damage. He also stated that this type of hearing loss is a gradual and painless process.

The reactions from those people wearing ear protectors at the present time indicates that there are some problems. The ear protectors must fit snugly to be effective and initially this is uncomfortable. As a result many workers do not wear them or alter them for comfort which reduces or or eliminates their effectiveness.

"The purpose of ear protectors is to put a barrier between the inner ear and the noise. Without it, the energy produced gradually destroys the delicate nerve endings which pick up sound vibrations and carry them to the brain."

Loudness is not the only damaging factor of noise. Time exposure, frequency of sound and individual sensitivity also play an important role. Until a method of decreasing everyday noise can be devised ear protectors seem to be the best answer.

Improvements Needed

Study Reveals Nursing Homes Lacking

Pennsylvania State University's department of sociology has completed a study examining the conditions, location, type of nursing care and sponsorship of 83 of Pennsylvania's 698 licensed nursing homes. The study, financed by the U.S. Public Health Service, reflects the federal government's growing concern about the increasing number of nursing homes throughout the country and their high turnover rates among personnel.

The study revealed that two major factors causing the high turnover rates, estimated at some 40 per cent, were low salary scales and overlapping of duties among the various types of nursing staff employed.

Personnel problems were also found to extend into the administrative positions with inadequately trained personnel. It was found that the administrators were either nurses with no business training or business professionals with no nursing training. Ideally, a business manager and director of nursing should be employed in each home.

Generally, the study revealed a need for better trained personnel, accurate job categorization and better personnel training programs to ameliorate the high turnover problems.

Internship In Acute Care Approved

The Medical College of Pennsylvania has been granted approval by the Council on Medical Education of the American Medical Association for an internship in acute care medicine. Marion S. Fay, Ph.D., acting president of the college announced that four such internships are planned.

According to Ethel Weinberg, M.D., associate dean and organizer of the internship program, the program is being instituted to meet the increased needs for a new kind of emergency room physician. The objective of the program is to develop the knowledge, skills and attitudes which will enable him to give excellent initial care and proper disposition to all patients who visit emergency rooms.

Inquiries concerning application to the acute care internship should be directed to David Wagner, M.D., associate professor, department of surgery, The Medical College of Pennsylvania, 3300 Henry Ave., Philadelphia, Pa.

Most Patients Have ENT Symptoms

A recent survey conducted by the Minnesota Academy of General Practice indicated that for the average family physician the greatest volume of patient care falls in the category of otolaryngology. Previous surveys conducted since 1966 have shown the volume of otolaryngological treatment consistently top ranking among twenty-four categories of patient care.

The 1970 survey showed 22 per cent of all patients visited family physicians for ENT care. This total was 62 per cent above patients requiring musculo-skeletal care, which ranked second, and 90 per cent more than obstetrical patients requiring office and hospital care, the third ranking category by volume.

The most common otolaryngological problems handled by family physicians, in their order of frequency are: upper respiratory infections, pharyngitis, tonsillitis, chronic rhinitis and otitis media.

The American Council of Otolaryngology noted that climate and geography may have some bearing on the results of the survey, but felt that Minnesota presents a good balance between urban and rural practice, and the high and low income groups.

Dr. Sunderman Heads Institute

F. William Sunderman, Sr., M.D., professor of pathology and co-chairman of the Department of Laboratory Medicine at Hahnemann Medical College and Hospital, has received an initial $100,000 grant from the Haas Community Fund to cover renovating and equipment purchasing expenses for the new Hahnemann Institute for Clinical Science.

Dr. Sunderman, "the Father of modern quality control in hospital laboratory procedures," will serve as director of the new institute, and will also serve as consultant to the Critical Care Laboratory at Hahnemann. The institute will seek to raise laboratory standards through extensive continuing education programs for pathologists and technicians.

The institute will develop a self-auditing studies program to compare individual laboratories with others and with standards set by the institute itself. Participants in the program will be given periodic opportunities to study new methods of laboratory technique.

PMS President-Elect To Head Program

George P. Rosemond, M.D., president-elect of the Pennsylvania Medical Society, is the program chairman for the Second National Conference on Breast Cancer to be held in May, 1971 in Los Angeles, Calif. The conference for physicians and allied scientists will present a multidisciplinary review of breast cancer problems including epidomology, etiology, detection, diagnosis and management.

Further information on the conference can be obtained by contacting: Esther Kelley, Professional Education, American Cancer Society, Inc., 219 East 42nd St., New York, N.Y. 10017.

New Air Quality Plan Aimed To End Confusion

It is expected that a proposal designating the entire state of Pennsylvania as a single federal air quality control region will soon be accepted. Victor H. Sussman, director of the Department of Health Bureau of Air Pollution Control, explained that the plan was requested by Governor Raymond P. Shafer last April. Under the proposed plan, six regions would be designated as federal air quality regions. Within each of these six regions "stringent controls for eleven airshed areas of heavy population and industrial concentration would continue to apply," while remaining areas would be subject to strengthened Pennsylvania air control standards.

With this type of plan Mr. Sussman said that much of the present duplication and confusion over control plans for each inter- and intrastate control region under the 1967 Federal Clear Air Act can be eliminated.

Environmental Researcher Named:

Paul Kotin Named New Temple Vice-President

The nation's top environmental research official has been named vice-president of Temple University for Health Sciences effective March 1, 1971.

He is Paul Kotin, M.D., director of the National Institute of Environmental Health Sciences in Triangle Park, North Carolina. His appointment to head the Temple University Health Sciences Center—which includes Temple University Hospital, the schools of medicine, dentistry and pharmacy and the College of Allied Health Professions—was announced by Dr. Paul R. Anderson, president of the university.

Dr. Kotin, a 54-year-old patho-

DR. KOTIN

logist and cancer researcher, was named the first director of the new national environmental center in North Carolina in 1966. At Temple he will succeed Leroy E. Burney, M.D., who resigned last September.

The institute, a division of the National Institutes of Health, seeks to identify factors in the environment that can adversely affect man. As its director, Dr. Kotin has urged the medical profession to pay more attention to the environmental causes of disease.

"Paul Kotin is that rare individual who combines strong leadership and administrative skills with significant accomplishments in research and public health," said Dr. Anderson. "Naturally, we are quite pleased that he will be setting the goals for the continued growth of the Health Sciences Center and its stated mission of teaching, research and patient care."

At Temple, Dr. Kotin will direct a medical center in North Philadelphia that employs more than 4,000 persons and holds research grants totaling more than $11 million. In addition to the hospital and the four colleges, it operates neighborhood health centers, a community mental health center and is affiliated with several of the city's leading medical institutions.

A graduate of the University of Illinois, where he earned his bachelor's degree in 1937 and his M.D. in 1940, Dr. Kotin was professor of pathology at the University of Southern California before joining the National Cancer Institute in 1962. He served as chief of the carcinogenesis studies branch and, later, in other capacities before being named to head the newly-created environmental institute in 1966.

Learning System On Depression Available To Physician Groups

MedCom, Inc., a company combining physician and creative talents, has developed a continuing education learning system on depression. The company currently has introduced its learning systems into the curricula of seventy medical schools. They are available through Lakeside Laboratories.

The learning system on depression is composed of three parts, prepared for family physicians, internists, surgeons, obstetricians, teaching psychiatrists and other physician groups. It includes an up-to-the-minute full-color, thirty-minute documentary film, a comprehensive monograph written by guest editors and a self-evaluation section. Causes, symptoms and treatment of depression are covered by the system.

The project is available to county societies, conventions, hospital staff, resident and intern groups, and any other group of interested physicians. Arrangements for these educational materials can be made by contacting Lakeside Laboratories, Inc., Milwaukee, Wis. 53201.

Army Issues Guidelines For Billing For Emergency Treatment

The department of the Army has issued guidelines to civilian medical doctors in billing the department for emergency treatment of military on authorized leave.

Identification showing full name, rank or grade, social security number and duty station should be copied and a copy of an authorized pass, official orders or travel orders retained for inclusion when submitting bills.

Notification of the patient's whereabouts and physical condition should be made immediately to the nearest Army Surgeon's Office. Costs incurred may be legitimately charged in the medical bill.

Billing should be submitted in quadruplicate with all identification information, dates of services and an itemized listing of charges for each type of service. This should be followed by a statement: "I certify that the services were necessary in the treatment of the above named person; that the services were as stated; and the charges are not in excess of those customarily made in this vicinity."

Pennsylvania physicians should mail such bills to the Commanding General, First United States Army, ATTN: Surgeon, Fort George G. Meade, Maryland 20755. The telephone number during duty hours is (301) 677-2566 or 677-3616; during off-duty hours the number is 677-4805 or 677-4826.

Task Forces Prepare For Conference On Aging

Two representatives from each of the more than 200 national organizations involved in planning the 1971 White House Conference on Aging will participate in task force studies of the problems and most crucial needs of the twenty million Americans sixty-five years of age or older.

Proposals submitted by the task force and those made by the community and state White House Conference during the first half of 1971 will "...provide a basis for deliberations of delegates at the National Conference when it meets in Washington in the week beginning November 28, 1971. Out of this conference, to which so many will have contributed, will come a plan of action for a more realistic and more comprehensive national policy on aging."

PENNSYLVANIA MEDICINE capitol report

In The Commonwealth

To Assist Health Planner

William J. Shaull has been appointed associate director for the Office of Comprehensive Health planning, Ellsworth R. Browneller, M.D., Pennsylvania secretary of health, announced recently. His duties in this new post will mainly focus on environmental aspects of comprehensive health planning, and on assisting Henry V. Walkowiak, director, in the development of a comprehensive and coordinated plan.

Conservation Film Available

"Of Natural Concern," is the subject of a film on the preservation of the environment now available to interested groups throughout the state. The film is the result of combined efforts of the Departments of Health and Agriculture.

It is hoped that the film will trigger the formation of additional local watershed groups in the Commonwealth in an effort to solve water and soil conservation problems.

Richard M. Boardman, the director of the Water Quality Division of the Department of Health, contends that water pollution, soil conservation and other environmental problems can best be confronted by local citizens over a given area. At present there are forty of these citizen-organized watershed associations in existence.

The film reveals the various types of environmental problems and educates people to take action to protect natural resources. Copies of the seventeen-minute color film are available from the Film Library, State Health Department, P.O. Box 90, Harrisburg, Pa. 17120.

In The Nation

Another weapon to be used in the fight against the cult of chiropractic has been made available by the American Medical Association. A brochure entitled "What They Say About Chiropractic" has now been published listing anti-chiropractic statements by nineteen different organizations.

Among the anti-chiropractic statements to be found in the new brochure is one by the AFL-CIO taken from a "fact sheet" submitted by that organization to the United States Senate Finance Committee on September 15 of this year.

The "fact sheet" said in part, "Care of patients should only be entrusted to those who have a sound scientific knowledge of disease and whose experience and competence render them capable of diagnosing and treating patients by utilizing all the resources of modern medicine. Since neither chiropractic theory nor the quality of chiropractic education equip chiropractors to do this, the AFL-CIO opposes coverage of chiropractic services in the Medicare Program."

One of the most devastating anti-chiropractic statements comes from the National Council of Senior Citizens. In the January, 1969 issue of "Senior Citizen News" the council said, "Chiropractic treatment, designed to eliminate causes that do not exist while denying the existence of the real causes, is at best worthless—and at worst mortally dangerous."

The statement from the Consumer Federation of America said in part, "...CFA is gravely concerned that Medicare coverage of chiropractic services would needlessly expose beneficiaries to potential health hazards—particularly the harm which would result when beneficiaries treated by such practitioners delay or avoid seeking proper medical care..."

PENNSYLVANIA MEDICINE medical memorabilia

Medical history, legends, and folklore present a fascinating backdrop to the current scene. From time to time it will appear in these pages to put current happenings in perspective. Your contributions will be welcome.

During the time of Hippocrates (Fifth Century B.C.) the methods of assisting the pregnant woman through her labor were often brutal. The woman was sometimes repeatedly lifted and dropped on a couch.

A variation of the method consisted of tying the woman to a bed, turning it on end and pounding it on a bundle of faggots (sticks) on the ground. The procedure, dispensed with by the Greeks, was revived in the Middle Ages in England and continued until after the Renaissance.

Nursing

The fifteenth century conception of the proper nurse to replace the mother incapable of suckling her child required the following qualifications. She must be of shapely stature, not too young nor too old, not too thin nor too plump, as any such defect in her body would cause a child's inclination toward that same defect. The good nurse was free of disease of the eye or body, chaste, modest, of good character and clean. She was to limit herself in, and if possible abstain from, sexual relationships as pregnancy was considered detrimental to her milk for the nursing child.

Dietary restrictions were also levied against the nurse. For example, she was not allowed to eat foods prepared in vinegar, bitter or sour foods, pepper or onion. Nor was she permitted to eat almonds or hazelnuts. She was to drink pure wine, preceed meals with gruel boiled in milk and eat a great quantity of peas and beans.

After Birth

During the Seventeenth Century, a baby at birth was washed and salted all over. Its head was then tightly bandaged to shape it. Next it was bound in swaddling bandages until it was unable to make the slightest movement. Once a day these bandages were removed and the child was permitted a few minutes for exercise. Swaddling continued for the first several months of the infant's life. Approximately one-half of babies treated in this manner died within their first year of life. In the United States one fifth of first-year deaths were attributed to the swaddling procedure.

SCIENTIFIC ASSEMBLY scenes shown above capture the activity of the meetings which drew over 1,000 participants. Shown at the top of the page is one of the exhibits in the learning lounge area where various learning methods and teaching techniques were displayed. Walter Tunnessen, M.D., in the foreground, tries a teletype-telephone link from Lancaster Host Farm Resort Motel to a computer link in New Jersey used to assist physicians in diagnosis. To the right, Alyce Gullattee, M.D., speaks at the eugenic sterilization conference. The photo next to the bottom of the page shows part of the crowd gathered for the general session on drug abuse. In the bottom photo Dorothy Novello, Ph.D., of Erie, far left, chairman of a panel discussion, speaks at the "Career Ladder" seminar for nurses and allied health professionals.

PMS House Adopts Long-Range Objectives

Medicine's commitment for the future is proposed in the long-term objectives adopted by the 1970 PMS House of Delegates as recommended by the Committee on Objectives. The major project of the committee during the past two years has been a study of the health care system with an eye toward future goals.

What the committee agreed upon was that medicine should be committed to (1) substantial increase in the volume of services to the public, (2) reasonable efficiency and reasonable cost in providing services, (3) a plan containing the potential for meeting comprehensive medical services, (4) satisfactory working conditions for physicians and personnel in the system provided, and (5) provision for the education and training of sufficient medical personnel.

The objectives developed by the committee and adopted by the House of Delegates are as follows:

"The Pennsylvania Medical Society is vitally concerned with the maintenance and improvement of all aspects of the health and welfare of the people. It will initiate and support worthy efforts, private and public, that may promote these aims and will provide leadership where appropriate.

Patient Care

"The Pennsylvania Medical Society will promote a climate in which its members can provide their patients with the best possible medical care, regardless of their ability to pay. With regard to concern for all aspects of the health of our citizens, the Pennsylvania Medical Society will, through appropriate channels, identify and relate to all members of the health team. It will establish and maintain meaningful relationships with allied professions and hospitals.

Ethics, Discipline, Licensure

"The Pennsylvania Medical Society will exert leadership on behalf of the public to assure that all persons providing personal health care meet satisfactory standards of training, competence, and performance. The Pennsylvania Medical Society, which is the custodian of the good name of Medicine in Pennsylvania, willingly exercises this stewardship in the interests of physicians, patients, and the public.

"As the steward of the physicians' rights and the arbiter of medical ethics, the Pennsylvania Medical Society will provide leadership in establishing guidelines for the unfolding relationships with hospitals and others concerned with the delivery of health services.

Delivery of Health Care

"The Pennsylvania Medical Society accepts the challenge of the search for new and better methods of delivering medical care more efficiently and acknowledges the cost of such delivery. We will attempt to provide leadership in its planning.

Manpower

"The Pennsylvania Medical Society accepts responsibility to evaluate the health manpower needs of the Commonwealth, and to assist the people of the state in meeting these needs. To these ends, it will inform the public of these needs and press for the establishment and maintenance of the necessary facilities and faculties.

"The Pennsylvania Medical Society will assist selected needy Pennsylvania students who seek careers in medicine and allied health fields.

"The Pennsylvania Medical Society will continued to encourage and recruit candidates for medical and allied careers.

Education

"The Pennsylvania Medical Society will participate actively in medical education by offering constructive suggestions to improve the content and quality of medical education in the Commonwealth.

"The Pennsylvania Medical Society will assume the task of assuring that practitioners maintain and increase their proficiency.

"The Pennsylvania Medical Society through its publications and meetings will foster an exchange of information among all those appropriate groups, both public and private, whose goal is the improved health and welfare of all citizens.

"The Pennsylvania Medical Society will meet its responsibility to advise the public concerning good health practices.

"The Pennsylvania Medical Society will cooperate with health departments and other appropriate bodies in studying and assisting in solving environmental problems. These include atmospheric and water pollution, thermal pollution, disposal of solid waste, and control of ionizing radiation.

Legislation

"The Pennsylvania Medical Society will initiate and support legislation expected to bring the greatest health benefits to the citizens of Pennsylvania. The Pennsylvania Medical Society will cooperate with government and private agencies to the end that health programs may operate effectively and economically."

The committee heard testimony by experts in the fields of prepaid medical care plans, group practice, the role of the solo practitioner and the problem of accessibility of medical care. Deliberations on the goals finally proposed took the testimony into consideration.

Family Practice List Available From Pitt

A bibliography on "Training for Family Practice" has recently been compiled at the University of Pittsburgh School of Medicine. It contains selected and annotated references from five areas of family practice: research in family practice, general references for training programs, training in family medicine, instructional and evaluative techniques and psychotherapeutic aspects of family practice. Copies of this bibliography are available at a cost of $2.00 by writing to the Staunton Clinic, 3500 Fifth Ave., Pittsburgh, Pa. 15213.

CORRECTION

In the authors' note which accompanied the paper "Estrogen Therapy In Atrophic Vaginitis," in the December, 1970, issue of PENNSYLVANIA MEDICINE, there appeared an error. George A. Kyriazis, M.D., one of the authors, is listed as having been formerly an assistant professor of obstetrics and gynecology at the University of Pennsylvania School of Medicine. He was, in fact, instructor in that field while there. Presently he is assistant clinical professor of obstetrics and gynecology at Hahnemann Medical College and Hospital, Philadelphia.

a once-popular treatment for back pains
was to have the seventh son of a seventh son
stand or walk on the patient's back.

The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

or headache, a sovereign remedy was
to wear a snakeskin round one's head.

A realistic approach to pain relief

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Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—
May be habit forming), Phenacetin gr. 2 1/2,
Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

B.W. & Co.' narcotic products are
Class "B", and as such are available on oral
prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Now that there's a greater therapeutic potential for treating Parkinson's disease and syndrome

...the information on these pages will be of practical interest to you

Larodopa® (levodopa) Roche : therapy that demands slow, individualized dosage titration

With the advent of new Larodopa (levodopa), there is now an agent that holds promise of relief of all the major symptoms of Parkinson's disease and syndrome—rigidity and akinesia as well as tremor.

However, as has been reported in the medical literature, levodopa demands slow, careful titration of dosage, and frequent patient monitoring. Adverse reactions may occur at any time, some serious enough to require dosage reduction or discontinuance of therapy. Thus, before prescribing, it is particularly important to refer to the following Important Therapeutic Considerations, the sections covering dosage and administration, and to the information on monitoring the patient (see prescribing information).

Important Therapeutic Considerations

Larodopa (levodopa) is an unusual drug which must be administered with particular care. In view of its high incidence of adverse reactions, you will find the following therapeutic considerations for Larodopa important:

(a) Larodopa is not curative and its mechanism of action is unknown, though postulated.

(b) Long-term safety and efficacy for Larodopa have not been established.

(c) Accurate diagnosis is imperative since there is no evidence that Larodopa is effective in neurological diseases other than Parkinson's disease and syndrome.

(d) About one-third of patients or more will not experience clinical improvement on Larodopa, and virtually 100% of patients will experience side effects of some degree.

(e) The dose of Larodopa producing maximal improvement with tolerated side effects must be *carefully titrated for the individual patient.*

(f) Finally, there is no evidence that early treatment with Larodopa, while possibly controlling symptomatology, alters the course of the disease.

Photographs of patients treated with Larodopa by permission of the patients.

Guide to dosage and administration of Larodopa® (levodopa) Roche

Usual daily dosage—initially, 0.5 to 1 Gm daily (divided in 2 or more doses with food).

Total daily dosage—increased gradually in increments of 0.125 to 0.75 Gm every 2 or 3 days, as tolerated.

Usual daily dose range—from 4 to 6 Gm given orally in 3 or more divided doses, with food.

Daily dosage should NOT exceed 8 Gm.

Optimal therapeutic dosage—usually reached in 6 to 8 weeks.

Establishing optimal dosage—must be determined and *carefully titrated for the individual*—gradually increase dosage until: (1) maximal response is seen, or (2) maximum recommended dosage is reached, or (3) side effects preclude further dosage increase, or require reduction or discontinuation of dosage.

Interrupted therapy—after brief interruption, dosage should again be adjusted gradually. (In many cases, the patient can be rapidly titrated to his previous therapeutic dosage. See "Precautions" section of Complete Prescribing Information.)

To underscore the extreme importance of careful dosage titration, the following week-by-week dosage pattern has been prepared, based on the assumption that the course of therapy is uninterrupted by any complications requiring a change in dosage. (Again, dosage must be reduced when intolerable side effects occur.)

Because it is absolutely imperative that Larodopa therapy be individualized to meet the particular needs of each patient, the following dosage schedule should be considered only a model.

Larodopa®
levodopa/Roche

Tration of Larodopa (levodopa) dosage ipatient evaluated weekly

Iervals	0.25 Gm Tablets	0.5 Gm Tablets	Total Daily Dose
Vek 1	½ tab (0.125 Gm) *q.i.d.* w/ food		0.5 Gm
Vek 2	1 tab (0.25 Gm) *q.i.d.* w/ food		1.0 Gm
Vek 3	1½ tab (0.375 Gm) *q.i.d.* w/ food		1.5 Gm
Vek 4		1 tab (0.5 Gm) *q.i.d.* w/ food	2.0 Gm
Vek 5		1½ tab (0.750 Gm) at breakfast and dinner. 1 tab (0.5 Gm) at lunch and bedtime	2.5 Gm
Vek 6		1½ tab (0.750 Gm) *q.i.d.* w/ food	3.0 Gm
Vek 7		2 tab (1.0 Gm) at breakfast and dinner. 1½ tab (0.750 Gm) at lunch and bedtime	3.5 Gm
Vek 8		2 tab (1.0 Gm) *q.i.d.* w/ food	4.0 Gm

Te daily maintenance dosage in the above example may increased, decreased, or maintained at the 4 Gm level pending upon the point at which optimal therapeutic ults are achieved.

ncurrent therapies: Larodopa (levodopa) may be used ncomitantly with other antiparkinsonism drugs such as hztropine mesylate (Cogentin), trihexyphenidyl HCl rtane) or procyclidine HCl (Kemadrin), but when more an one drug is used, the usual dose of each may have to reduced.

t to be given concomitantly: MAO inhibitors. Such ents must be discontinued two weeks prior to initiating rodopa therapy.

te of caution for patients who require vitamin plementation: It has been reported that pyridoxine HCl tamin B_6) can rapidly reverse the antiparkinson effects evodopa therapy.

timetable for monitoring

ile it cannot be emphasized too strongly that each ient on Larodopa must be treated as a totally *distinct* tity, the following are suggested as guidelines in the nitoring of such patients.

For the first month, at least: the average ambulatory tpatient should be seen and evaluated a minimum of *once week.*

During the second month: patient evaluations can be tended to *every two weeks* (assuming no laboratory normalities or intolerable side effects have occurred).

3. From the third through the sixth month: the patient should be evaluated *once a month.*

4. After six months on the appropriate maintenance dose: with no significant adverse reactions or laboratory abnormalities, the patient should be seen at least *once every two months.*

5. Finally, after one year on maintenance dosage: evaluation should be made no less than *once every three months.*

Therapeutic response

A favorable response may often be seen within 10 days to several weeks. However, a patient should not be taken off a tolerable dose—even in the absence of a response—until six months have elapsed. This is because, in some instances, the response may come relatively late. Of course, any serious laboratory abnormalities or intolerable side effects automatically dictate discontinuance of therapy.

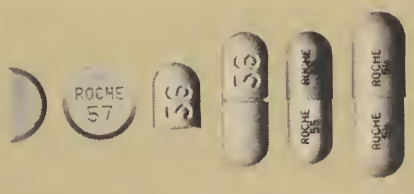
Lessening the side-effects problem

While it is generally advisable that levodopa be taken after meals, nausea and vomiting, two frequently occurring side effects of levodopa, can often be minimized by taking medication with foods. If nausea becomes intolerable, the dosage should be cut back in daily decrements equal to the most recent increments given the patient. This reduction is to be spaced over two- or three-day intervals. Conversely, as nausea subsides, the drug dosage should be slowly increased in like increments.

An important part of the routine monitoring procedure would be to determine any possible cardiovascular problems. If cardiac arrhythmias occur, Larodopa should be discontinued and other antiparkinson therapy instituted. With orthostatic hypotension a possibility, checking the patient's blood pressure (both supine and standing) is essential.

If choreiform movements appear, they usually occur when maximum therapeutic dosages are reached. To control such effects, reduce dosage by decrements of 0.5 Gm daily.

Flexible dosage: scored tablets of 0.25 Gm and 0.5 Gm help simplify dosage titration



Conveniently scored 0.25 and 0.5 Gm tablets make possible more precise titration. Should another dosage form be preferred, Larodopa is also supplied in capsule strengths of 0.25 and 0.5 Gm.

Before prescribing, please consult product information on next page. →

Larodopa®
levodopa/Roche

For the relief of symptoms associated with Parkinson's disease and syndrome

Before prescribing, please consult complete product information, a summary of which follows:

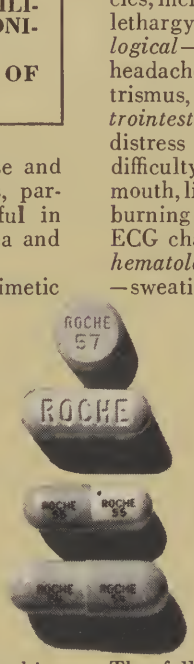
BECAUSE OF THE HIGH INCIDENCE OF ADVERSE REACTIONS AND THE NECESSITY FOR INDIVIDUALIZING THERAPY, THE PHYSICIAN SHOULD THOROUGHLY FAMILIARIZE HIMSELF WITH THE INFORMATION IN THE PACKAGE INSERT BEFORE INSTITUTING THERAPY WITH LARODOPA (LEVODOPA). ACCURATE DIAGNOSIS IS IMPERATIVE BECAUSE EVIDENCE IS LACKING THAT LARODOPA IS EFFECTIVE IN NEUROLOGICAL DISEASES OTHER THAN PARKINSON'S DISEASE AND SYNDROME.

ADEQUATE CLINICAL AND LABORATORY FACILITIES SHOULD BE AVAILABLE FOR PROPER MONITORING OF TREATMENT.

THE LONG-TERM SAFETY AND EFFICACY OF LARODOPA HAVE NOT BEEN ESTABLISHED.

Indications: For the treatment of Parkinson's disease and syndrome. Useful in relieving many of the symptoms, particularly rigidity and bradykinesia; frequently helpful in management of associated tremor, dysphagia, sialorrhea and postural instability.

Contraindications: In patients for whom a sympathomimetic amine is contraindicated; in patients receiving MAO inhibitors (the latter should be discontinued two weeks prior to initiating therapy with Larodopa); in patients with clinical or laboratory evidence of **uncompensated** endocrine, renal, hepatic, cardiovascular or pulmonary disease; with narrow angle glaucoma and blood dyscrasias; in patients with known hypersensitivity to levodopa.



Warnings: Long-term safety and efficacy not established. Administer with extreme caution to patients with bronchial asthma or emphysema who may require sympathomimetic drugs; to those with active peptic ulcer (in facilities equipped to treat gastrointestinal hemorrhage); in patients with psychoses or severe psychoneuroses. Initiate therapy with extreme caution and in proper treatment facility in patients with a history of myocardial infarction who have residual atrial, nodal or ventricular arrhythmias. Monitor all patients for development of mental changes, depression with suicidal tendencies, other serious antisocial behavior. Carefully consider concomitant administration of pyridoxine hydrochloride (vitamin B_6); oral doses of 10 to 25 mg have been reported to rapidly reverse the antiparkinson effects of Larodopa. In pregnancy, weigh potential benefits against possible hazards. Do not use in nursing mothers. Safety of Larodopa in children under age 12 not established.

Precautions: During extended therapy, periodic evaluations of hepatic, hematopoietic, cardiovascular and renal function recommended. In diabetic patients, control may be adversely affected; careful, frequent monitoring and proper adjustment of antidiabetic regimen required. Patients with chronic wide angle glaucoma may be treated cautiously provided intraocular pressure is well controlled and patient is monitored carefully. Monitor carefully patients receiving antihypertensive agents or psychoactive drugs concomitantly, or those with history of convulsions. If general anesthesia is required, discontinue Larodopa 24 hours prior to surgery; monitor cardiorespiratory functions carefully. Patients who improve on Larodopa therapy should resume normal activities cautiously. May be used concomitantly with other antiparkinson drugs with possible reduction in dosage of each.

Adverse Reactions: *Most frequently occurring:* nausea, anorexia, emesis, cardiac irregularities, orthostatic hypotension; choreiform, dystonic and other adventitious movements; dizziness, sedation, dyskinesia; psychiatric symptoms such as agitation, anxiety, confusion, depression, hallucinations, delusions, insomnia, nightmares, and mental changes including paranoid ideation and psychotic episodes. *Less frequently occurring* and listed according to system: *psychiatric*—suicidal tendencies, increased libido with serious antisocial behavior, euphoria, lethargy, stimulation, fatigue and malaise, dementia; *neurological*—ataxia, convulsions, faintness, impairment of gait, headache, increased hand tremor, akinetic episodes, torticollis, trismus, oculogyric crisis, weakness, numbness, bruxism; *gastrointestinal*—constipation, diarrhea, epigastric and abdominal distress and pain, flatulence, eructation, hiccups, sialorrhea, difficulty in swallowing, bitter taste, dry mouth, tightness of mouth, lips or tongue, duodenal ulcer, gastrointestinal bleeding, burning sensation of the tongue; *cardiovascular*—nonspecific ECG changes, palpitations, hypertension, flushing, phlebitis; *hematological*—hemolytic anemia (1 case); *dermatological*—sweating, edema, hair loss, pallor, rash, bad odor; *musculoskeletal*—low back pain, muscle spasm and twitching, blepharospasm, musculoskeletal pain; *respiratory*—feeling of pressure in the chest, cough, hoarseness, bizarre breathing pattern, postnasal drip; *urogenital*—urinary frequency, retention, incontinence, hematuria, nocturia, and one report of interstitial nephritis; *special senses*—blurred vision, diplopia, dilated pupils, activation of latent Horner's syndrome; *other*—fever, hot flashes, weight gain or weight loss.

Nausea, anorexia and vomiting usually obviated by temporary dosage reduction and/or administration with food. If cardiac arrhythmias occur, discontinue and institute other antiparkinson therapy. Reduce dosage when involuntary movements occur.

The following have been noted: elevation of BUN, SGOT, SGPT, LDH, bilirubin, alkaline phosphatase or PBI; occasionally, reductions in WBC, hemoglobin and hematocrit; elevations of uric acid with use of colorimetric method but not with uricase; rarely, positive Coombs test; dark sweat and urine.

Dosage and Administration: Because of the strong possibility of adverse reactions and the necessity for individualizing therapy, the physician should thoroughly familiarize himself with the information in the package insert before instituting therapy.

How Supplied: *Tablets*, pink, scored, containing 0.25 Gm levodopa (imprinted Roche 57) or 0.5 Gm levodopa (imprinted Roche 56)—bottles of 100 and 500.

Capsules, containing 0.25 Gm levodopa (pink and beige, imprinted Roche 55) or 0.5 Gm levodopa (pink, imprinted Roche 54)—bottles of 100 and 500.

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

The girth control pill

Tepanil® Ten-tab

(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

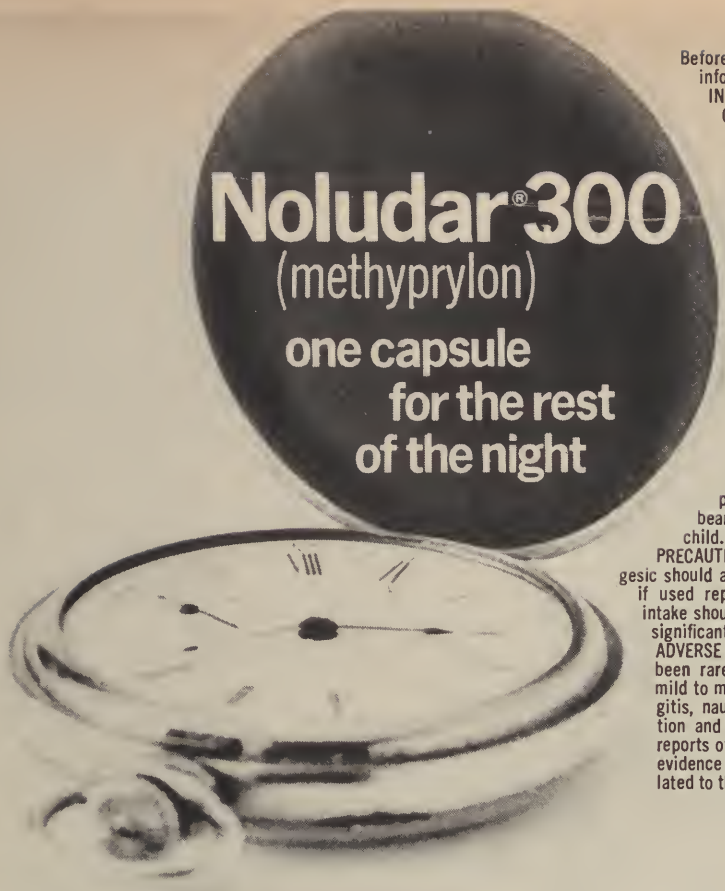
Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps

0915A



Before prescribing, please consult complete product information, a summary of which follows:

INDICATION: Relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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Nutley, New Jersey 07110

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The blowfish, a small spec
of fish, reacts to stress or
fright by puffing itself up
air. After about a dozen
noisy gulps the belly is bal
shaped and hard. When
replaced in the water the
quickly expelled, and
the fish sinks to the botto

..in the presence of spasm or hypermotility, gas distension and discomfort, **KINESED®** provides more complete relief:

☐ belladonna alkaloids—for the hyperactive bowel ☐ simethicone—for accompanying distension and pain due to gas ☐ phenobarbital—for associated anxiety and tension

Composition: Each chewable, fruit-flavored, scored tablet contains: 16 mg. phenobarbital (warning: may be habit-forming); 0.1 mg. hyoscyamine sulfate; 0.02 mg. atropine sulfate; 0.007 mg. scopolamine hydrobromide; 40 mg. simethicone.

Contraindications: Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.

Precautions: Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.

Side effects: Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.

Dosage: Adults: One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms. Children 2 to 12 years: One half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

STUART PHARMACEUTICALS | Pasadena, California 91109 | Division of ATLAS CHEMICAL INDUSTRIES, INC.

(from the Greek **kinetikos**,
to move,
and the Latin **sedatus**,
to calm)

KINESED®

antispasmodic/sedative/antiflatulent

Rap-line A Success

PMS Council Gives 'Public Service'

"Hello, this is rap-line..." was the phrase used in answer to the ring of one of the telephones. The woman calling was a thirty-eight year old housewife with two young children. She lived in a middle-class neighborhood in a city in northeastern Pennsylvania. And she was a drug abuser. The individual who answered her call was a physician. For the first time in ten years of chronic, heavy use of amphetimines and barbiturates, she was asking for help to get off the drugs.

A seventeen year old girl from York cried into the telephone. She was trying to kick the herion habit "cold turkey" (without assistance from other drugs), and she was scared. The call was taken by a twenty-one year old former addict. He had been through it. "You can make it," he told her. She did.

Drug abuse is serious. Solutions to the growing problem are not easy to find. Efforts often end in frustration for the community and for drug users. Finding a means of communication between those knowledgeable people in the "straight" world and followers of the drug culture has often ended in defeat.

But recently, when a representative of the Susquehanna Broadcasting Co., with stations in Pennsylvania, Ohio, New York, Rhode Island and Florida, contacted the Council on Public Service of the State Society, he came with an idea for communicating facts on drug abuse to the public, and he needed the cooperation of the radio-television department of the Council.

The broadcasting company's idea was to offer a telephone counseling service for one day. Experts including physicians, former addicts, lawyers and clergymen, would man the telephones to be installed especially for the day. The plan called for heavy station promotion throughout the day, with all calls handled confidentially and answered off the air.

The Council on Public Service and Susquehanna Broadcasting Co., arranged the first program using the facilities of WSBA, the Susquehanna station serving the Harrisburg, York and Lancaster areas. Over thirty experts from various fields agreed to participate in the project, even though no-one knew what to expect from the unique effort.

On June 30, 1970, the volunteer experts, each donating from two to eight hours, assembled in the studios of WSBA. "Drug Abuse Rap-Line," the title given to the entire program, had been publicized well in advance to station listeners. At noon six special telephone lines were opened for questions. For the next twelve hours the phones never stopped ringing. It was estimated that the station received over 2,000 calls from interested, serious, often deeply troubled people.

Several parents wanted help in identifying symptoms of drug use. They hesitated asking their family physicians.

A number of teenagers talked to former drug users. They asked, "Are drugs really that bad?" The answer was, "Worse."

Throughout the day physicians, lawyers, Health Department officials, pharmacists, psychiatrists, former addicts and police officials answered questions and offered help. There was no preaching—just straight fact.

Mr. Sam Toggas, president of the York County Pharmaceutical Association, said, "I have spoken to many school and adult groups and tried to answer their questions. After this program I know what people have on their minds."

Following the success of the WSBA venture, similar arrangements were made to produce a program at WARM, Susquehanna's second Pennsylvania radio station, which covers the Scranton-Wilkes-Barre area. Held on November 14, the program was, if anything, more successful—handling more calls, with a greater number of calls being of a serious nature. Rev. Frank Reynolds, executive director of the Rehrersburg Teen Challenge Rehabilitation Center, said, "Several of the youngsters I spoke with were high on drugs when they called. One young girl was calling from a pot party. Her parents thought it was a pajama party."

A seventeen year old Wilkes-Barre boy actually came into the station after having sniffed six tubes of glue. He talked privately with Robert F. Babskie, M.D., of the Luzerne County Medical Society, one of the many volunteers from the county societies in the areas involved.

Mr. Thomas Zompanis, a former drug addict and now director of Gaudenzia House in West Chester, remarked, "The people in this area

DURING the Rap-line show at WARM, Scranton-Wilkes-Barre, the group of participants shown above took time out from answering telephones to tape shows for future broadcasting, while other volunteers manned the busy telephones. Above, left to right, are M. E. Barnes, M.D., Wilkes-Barre; William K. Panacci, president of the Lackawanna County Pharmaceutical Association; Dan Kusick of the Scranton Times; Bess Richardson, executive director of the Alcoholism and Drug Abuse Council of Northeast Pennsylvania; Paul Mazzoni, Lackawanna County district attorney; Blythe H. Evans, Luzerne County district attorney; Nello Ricetti, assistant superintendant of the Pittston Area School District; Robert Feldman program director for WNEP-TV; Jerry Heller, news reporter for WARM and John Lounds of Gaudenzia House, Philadelphia.

N ACTION on Rap-line at WARM, Scranton-Wilkes-Barre, are, left to right, James P. O'Leary of the PMS staff; William K. Panacci, president of the Lackawanna County Pharmaceutical Association; Pete Gabriel, WARM public service director; Jerry Heller, WARM; Blythe H. Evans, Luzerne County district attorney; Bess Richardson, executive director of the Alcoholism and Drug Abuse Council of Northeast Pennsylvania, and Guido D. Boriosi, M.D., of the Lackawanna County Medical Society.

hould wake up—they really have a lrug problem."

Perhaps the people are waking up. 'he two Susquehanna stations comnand large listening audiences in their espective areas. The programs received elevision and newspaper coverage, and apes were made for rebroadcast. In umbers of listeners the stations inolved are topped only by stations in he Philadelphia and Pittsburgh areas. 3ut among those listeners were loubters. One listener called to comlain, "We don't have that kind of roblem around here." The lawyer vho took that call replied, "If you eally believe that, sir, why don't you ome down and help us answer these alls?"

Navy Offering Aid To Med Students

The Department of the Navy is ffering scholarships to medical and steopathic students in the class of 975. The scholarships will cover full uition and authorized fees, $200 anually for books, medical care for elf and dependents, and pay ranging rom $6,600 to $10,820 per annum. ive years of active naval service folowing internship is required of all articipants in the scholarship program.

Applications for the scholarship will e at the main naval recruiting stations n Pennsylvania located at the Blackurn Building, 13 S. Thirteenth St., hiladelphia, and at the Federal Buildng, 1000 Liberty Ave., Pittsburgh etween January 1 and March 15, 971. Notification of selection will e made about July 1, 1971.

Further information may be obtained by contacting the Surgeon General, Department of the Navy, Washington, D.C. 20390 (Attn: Code 3174)

Government Issues Warning Against Exercise Device

The U.S. Food and Drug Administration has issued a public warning against the use of a device called a "Relaxacizor", which causes passive muscle contraction with an electrical current applied through electrodes to various parts of the body.

The United States District Court has ruled that the device is "dangerous to health". Approximately 400,000 units have been sold since 1949 and many of them are still being used despite their certified dangers. The FDA says that in some instances the units are being sold although the sale is illegal.

The District Court ruled that the "Relaxacizor" may: "Aggravate many medical conditions in susceptible persons; have a serious potential for damage to the heart and other vital organs; and, be capable of causing a miscarriage, and otherwise may jeopardize the health and even the life of the user."

The device is about the size of a briefcase with dials to regulate current intensity and pulse frequency and with a number of electrodes for placement on the chest, abdomen, hips and legs. Sales literature claims that the device enhances muscle relaxation and muscle tone.

Further information is available from the FDA, 5600 Fishers Lane, Rockville, Maryland 20852.

Jefferson Gets Grant

The National Institutes of Health has awarded $1,700,000 to Thomas Jefferson University for the establishment of a radiation therapy research and clinical center. The center will be run under the direction of Simon Kramer, M.D., professor and chairman of the department of radiation therapy and nuclear medicine.

The grant will allow for vast expansion of the department's present clinical and research services. The expansion program is scheduled for completion in June, 1972.

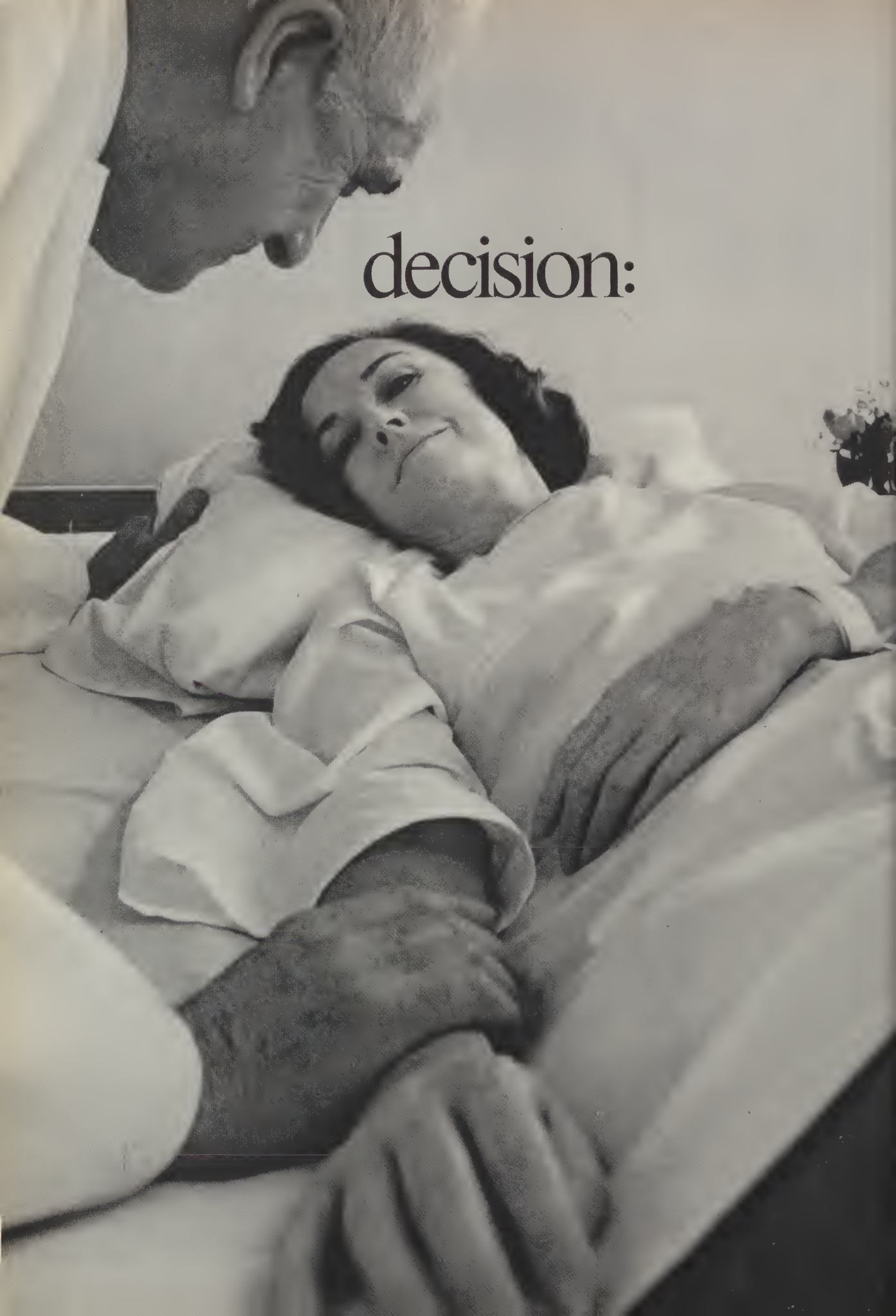
Philadelphia To Install Officers

The newly elected officers of the Philadelphia County Medical Society were announced at the society's annual meeting, December 9, 1970.

The new officers are, George A. Hahn, M.D., president; Robert R. Tyson, M.D., president-elect; David S. Cristol, M.D., vice-president; Brooke Roberts, M.D., secretary; Alma Dea Morani, M.D., treasurer.

In keeping with the society's bylaws, the new officers will have their formal installation ceremonies January 20, 1971.

George A. Hahn, M.D., 110th president of the society brings to the presidency a long and varied experience. His particular professional interest in pelvic malignancy in the female is known to all physicians. His efforts cover clinical experience, research and investigation, and the teaching of medical students and other doctors. Most of his teaching career has been spent at Jefferson Medical College, first as assistant demonstrator of gynecology in 1941. He was appointed professor of obstetrics and gynecology in 1963.


decision:

Loridine® I.M.
Cephaloridine

1.5 to 3 Gm. daily successfully treats many moderately severe infections*

- bactericidal action in vitro against susceptible organisms causing:
  pneumonia
  urinary tract infections
  septicemia
  abscesses
- broad-spectrum activity
- relatively painless I.M. injection

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

Lilly 000903

Loridine®
CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

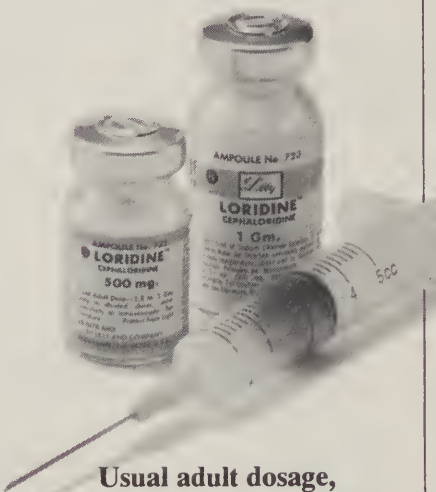
Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Loridine®
CEPHALORIDINE



Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber stoppered; 1 Gm., 10-ml. size, rubber stoppered. [0821

Additional information available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly

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m.d.'s in the news

Donald H. Roberts, M.D., Mechanicsburg, and Joseph A. Nizolek Jr., M.D., Florida, N.Y., have accepted appointments as assistant professors of anesthesiology at the Milton S. Hershey Medical Center.

It was announced recently that Howard Balin, M.D., Philadelphia, has been named professor of obstetrics and gynecology and head of the division of reproductive biology at Hahnemann Medical College and Hospital. His new division will be concerned with the application of recent research information to the problems of sterility, fertility and family planning.

Four physicians have been added to the senior staff at the Guthrie Clinic, Sayre. They are: Edward A. Talmadge, M.D., chairman of the department of anesthesiology; Gerald L. Mackler, M.D., a member of the division of internal medicine and a section of hematology; Richard E. Snelling, M.D., with the division of internal medicine and Ephriam E. Leguizamon, M.D., with the division of cardiology.

The 1970-1971 officers of the Pittsburgh Otological Society have been elected. They are: Clyde B. Lamp, Jr., M.D., president; Ralph J. Caparosa, M.D., vice-president and Bruce B. Macmillan, M.D., secretary-treasurer.

Sheldon Adler, M.D., has been appointed associate professor of medicine at the University of Pittsburgh. Affiliated with the school since 1966, Dr. Adler is also chief of the renal unit at Montefiore Hospital and a member of the University Health Center of Pittsburgh.

Andre B. Borle, M.D., associate professor of physiology at the University of Pittsburgh School of Medicine, received the Prix Andre Lichwitz of the French Institut National De La Sante Et De La Recherche Medicale. The award is presented annually to the individual or team of researchers making outstanding contributions to the field of calcium and phosphate metabolism.

Henry L. Price, M.D., has been named professor of anesthesiology and co-director of anesthesia research at Temple University School of Medicine. He is the author or co-author of more than eighty papers in his field and is a consultant to the National Institutes of Health and to the Naval Hospital in Philadelphia.

William S. Frankl, M.D., has been appointed professor of medicine at the Medical College of Pennsylvania. He will assume duties as head of the cardiac section of that department. Dr. Frankl and his colleagues have been instrumental in establishing a broad based program for the diagnosis and treatment of all forms of heart disease.

ROBERT W. GIBSON, M.D., left, director of the Sheppard and Enoch Pratt Hospital in Towson, M.D., speaks with J. Martin Myers, M.D., center, psychiatrist-in-chief of Pennsylvania Hospital and Leo Madow, M.D., right, president of the Philadelphia Psychiatric Society, after receiving the 1970 Strecker Award created to honor the memory of Edward A. Strecker, M.D., a distinguished psychiatrist, author, educator and past president of the American Psychiatric Association. Dr. Gibson has been instrumental in extending psychiatric coverage to Medicare and Medicaid patients and continually investigates the psychotherapeutic approach to schizophrenic patients. He is chairman of the Gimsburg Fellowship Committee in the Group for the Advancement of Psychiatry and is vice-president of the National Association of Private Psychiatric Hospitals.

Donald R. Cooper, M.D., was recently installed as president of The Frederick A. Coller Surgical Society. Dr. Cooper is a professor and chairman of the department of surgery at the Medical College of Pennsylvania.

W. Robert Felix, Jr., M.D., an instructor in surgery at the Medical College of Pennsylvania, was named a fellow of the American College of Surgeons at the association's annual meeting in Chicago.

Joseph B. Kahn, M.D., has been appointed a part-time associate in the department of orthopedics at Geisinger Medical Center. In addition to this appointment he has a general and surgical practice in Selinsgrove, and part-time appointments at the U. S. Penitentiary at Lewisburg and at the Doctors' Convalescent Center in Selinsgrove.

C. Everett Koop, M.D., surgeon-in-chief at the Children's Hospital of Philadelphia, served on two postgraduate course panels at the 1970 Clinical Congress of the American College of Surgeons in Chicago. Dr. Koop discussed obscure and chronic abdominal pain and surgical and radiologic and chemotherapeutic treatment of malignant tumors in childhood.

Sylvan E. Stool, M.D., chief of otolaryngology and senior surgeon at the Children's Hospital of Philadelphia, took part in a short course on airway management in Las Vegas, Nev., during a meeting of the Ophthalmologic and Otolaryngological Society.

Ralph E. Pilgrim, M.D., and Harry M. McDermott, Jr., M.D., have been named associate directors of the Ritenour Health Center at the Pennsylvania State University, University Park.

Two University of Pittsburgh professors, Ralph J. Caparosa, M.D., assistant professor of otolaryngology, and Sidney N. Busis, M.D., clinical associate professor of otolaryngology, opened the 1970-71 Visiting Professor Program at the Geisinger Medical Center. They presented lectures on hearing nerve tumors.

With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

EVAC-U-GEN®

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): ½ tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

W-C PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.

WALKER, CORP & CO., INC.
Syracuse, New York 13201

Changes Shown

PMS, AMA Membership Classifications Listed

ACTIVE MEMBER - Any physician who is fully licensed to practice medicine and surgery in the Commonwealth of Pennsylvania and is a member of a component society.

Dues: PMS - $75.00
AMA - $110.00 (AMA dues may be excused (1) by reason of financial hardship or illness, or (2) if member is retired from active practice.)

Benefits: PMS - All
AMA - All membership privileges except that benefits for AMA dues-exempt membership (1) or (2) above are the same as Resident (below).

INTERN AND RESIDENT - (ACTIVE MEMBER) - Any Active Member serving a hospital internship, residency, or other recognized full-time postgraduate training.

Dues: PMS - $7.50 (10 per cent of regular assessment)
AMA - Dues-exempt

Benefits: PMS - All
AMA - All except scientific publications which are available to such members at reduced subscription rates.

MILITARY - (ACTIVE MEMBER) - Any Active Member serving *temporarily* in the Armed Forces. (Must be in Armed Forces prior to March 1).

Dues: PMS & AMA - Dues-exempt

Benefits: PMS - All
AMA - Same as Resident

DISABILITY - (ACTIVE MEMBER) - Any member who is prevented from the practice of medicine by reason of illness or disability.

Dues: PMS & AMA - Dues-exempt

Benefits: PMS - All
AMA - Same as Resident

SENIOR ACTIVE MEMBER - Any member at least 65 years of age on January 1 with at least 30 years continuous membership (membership in other states or AMA may be included).

Dues: PMS - $37.50 (50 per cent of regular assessment)
AMA - $110.00 (AMA dues may be excused (1) by reason of financial hardship or illness, or (2) if member is retired from active practice.

Benefits: PMS - All
AMA - Same as Active Member except that benefits for AMA dues-exempt membership (1) or (2) above are the same as Resident.

ASSOCIATE MEMBER - Any Active or Senior Active Member who is at least 70 years of age and who has at least 30 years continuous membership (membership in other states or AMA may be included).

Dues: PMS & AMA - Dues-exempt

Benefits: PMS - All - except cannot vote, hold an office, serve as delegate, membe

of a commission, committee, or council, and is not entitled to benefits of Medical Defense Fund for alleged malpractice committed while an Associate member.

AMA - May not vote or hold office and will not receive scientific publications except by direct subscription.

AFFILIATE MEMBER - Any member of a component society who belongs to one of the following classes:

(a) Members of national medical societies of foreign countries.

(b) American physicians whether or not licensed to practice medicine and surgery in Pennsylvania engaged in missionary or philanthropic labors.

(c) Persons who are eligible to be Service Members of the AMA (career military or other Government employees).

(d) Full-time teachers of medicine or of the arts and sciences allied to medicine who are not holders of an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania.

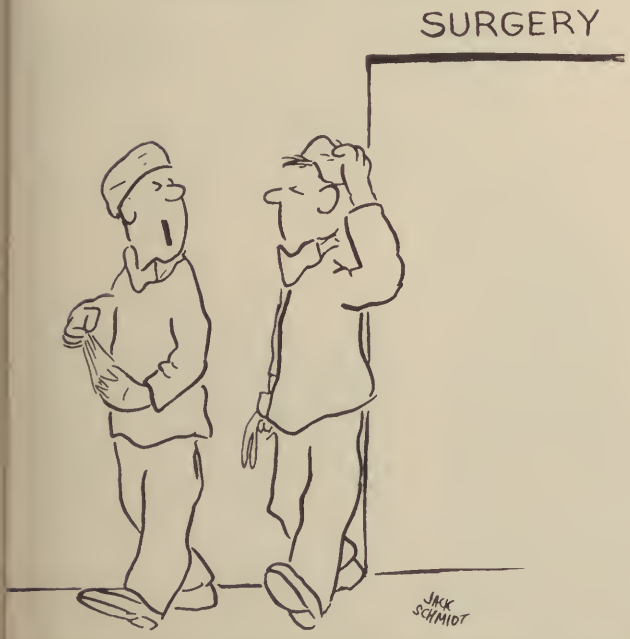
(e) Physicians not fully licensed to practice medicine in Pennsylvania who are engaged in Pennsylvania in research, public health or administrative medicine.

(f) Physicians, whether or not fully licensed to practice medicine in Pennsylvania, who are retired from active practice.

Dues: PMS & AMA - Dues-exempt

Benefits: PMS - All - except cannot vote or hold any office, serve as a delegate, member of a commission, committee, or council, and is not entitled to benefits of Medical Defense Fund for alleged malpractice while an Affiliate member or for benefits of Medical Benevolence Fund.

AMA - Same as Associate Member.



...at was a nice opening Ted, but I would have led in spades.

With QUĪ-A-ZONE — you can sedate effectively. A balanced combination of short, intermediate, and long-acting barbiturates (totaling 100 mg.) in a rapidly disintegrating tablet — sedation is provided within a few minutes . . . followed by sound restful sleep . . . usually without morning hangover. The four barbiturates in QUĪ-A-ZONE have dual channels of elimination (renal and hepatic) to lessen metabolic burden, decrease barbiturate retention, and minimize depression.

QUĪ-A-ZONE™

Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.
Usual Adult Dose: 1 to 2 tablets before retiring.
PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

W-C PRECISION PHARMACEUTICALS

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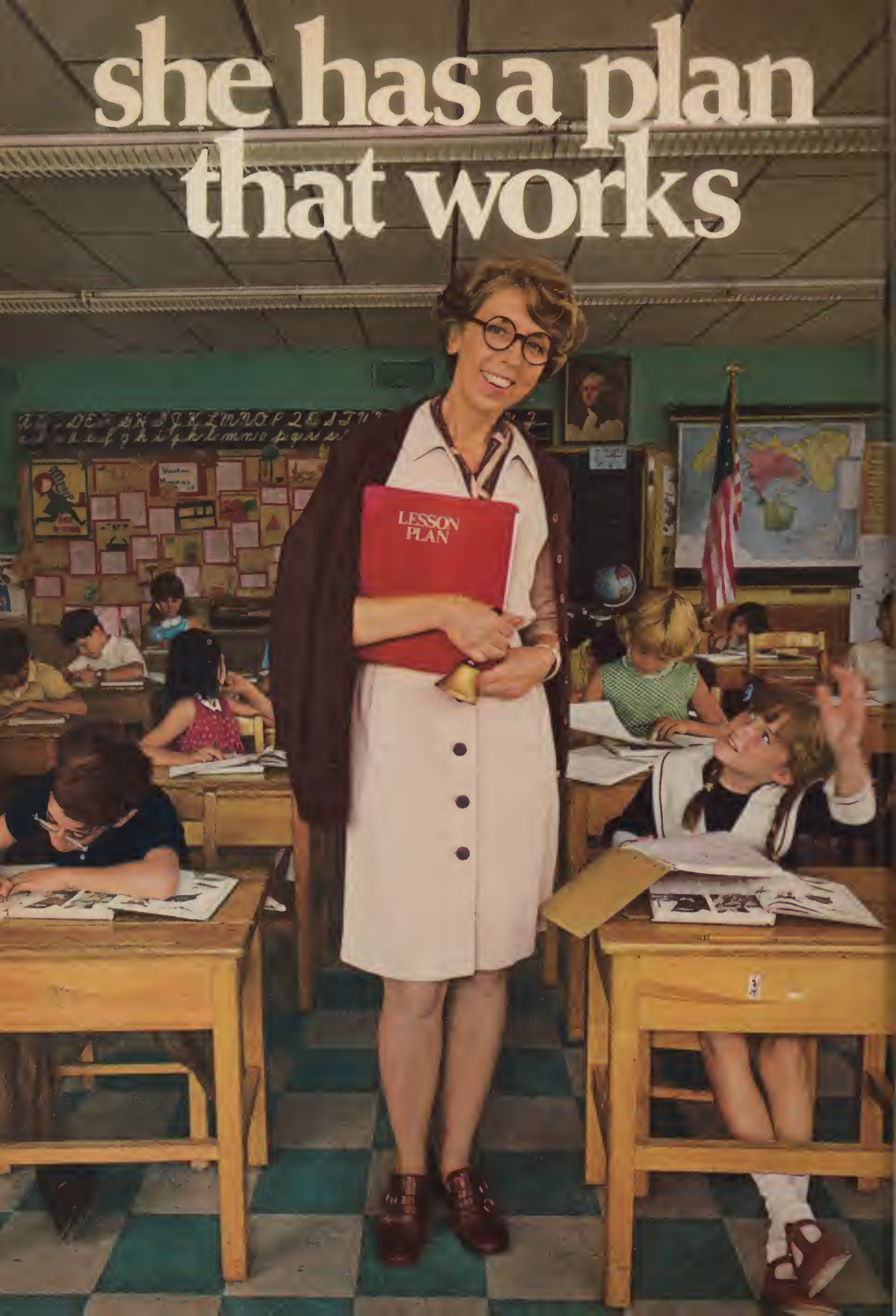
Syracuse, New York 13201


she has a plan
that works
LESSON
PLAN

She has a plan that works.

She has one plan for the lass. And they really respond.

She has another plan just or herself. A medication plan or her hypertension. And she's lso responding beautifully.

More than just another ntihypertensive, Ser-Ap-Es an be a whole medication plan or living with hypertension.

Does it get good marks for omfort?

Excellent. Because er-Ap-Es controls blood pres- ure effectively, dosage of each omponent is lower than if pre- cribed alone, usually minimiz- ng side effects. However, side ffects may occur (see prescrib- ng information).

Designed with the kidney n mind?

Hydralazine maintains r increases renal blood flow.

And the brain too?

Hydralazine also relaxes erebral vascular tone. And eserpine has beneficial calm- ng action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

Practical on a teacher's salary?

Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits…

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

CIBA

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

a plan for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

INDICATIONS: All cases of hypertension except the mildest and the most severe.

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

Hydralazine: Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Reserpine: The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydralazine: Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

Hydralazine: Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage.

Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop.

Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Reserpine: Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

Hydralazine: Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE: One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

SUPPLIED: *Tablets* (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Summit, New Jersey

2/4624

she has a plan that works for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

CIBA

New Program Attacks Alcoholism

- One out of eight American adults is already well on his way to becoming an alcoholic.
- Only three per cent of all alcoholics are on skid row.
- There is no known cure for alcoholism.
- The less a drinker knows about alcoholism, the greater is the danger of his becoming an alcoholic.
- Alcoholism can happen to anyone who drinks.

These are facts. They explode many myths about drinking and alcoholism.

Campaign to Educate

These facts, and the myths they explode, are but a part of the new statewide campaign Pennsylvania Blue Shield is launching with a forty-page illustrated booklet entitled "The Alcoholic American." The booklet, part of an extensive public health education project on alcoholism, explores the disease, its causes, the types of drinkers,, the myths, the prevention, and the available methods of cure.

The frightful thing about alcoholism is the fact that it can happen to anyone who drinks and it can become so much a part of anyone's life that even he does not realize how important alcohol is to him until it is too late—or very nearly too late!

The Blue Shield assault on alcoholism in Pennsylvania also includes a two-film series entitled, "The Other Guy," which tells the story of a young executive who falls prey, unwittingly, to alcoholism. The story tells how he got that way and the problems he created for himself, his family and his friends. The second part shows his battle to overcome the disease and the pitfalls that confront him. The films are expected to be shown on television stations across the state in the near future.

Blue Shield's booklet and film attack on alcoholism was previewed in Pennsylvania last fall at the Governor's Conference on Alcoholism in Bedford Springs. It was included in the session on alcoholism at the PMS Scientific Assembly last November.

There is a point where the alcohol-dependent drinker will argue vehemently that he can cut it out with no difficulty, then go to elaborate lengths to sneak a drink from hidden bottles.

Even when a confirmed alcoholic has dried out and has kicked the habit, he will swear he can still drink occasionally and control it. The fact is, an alcoholic can never drink reasonably... nor can the reformed alcoholic! Too many times the dried out alcoholic drinks himself into a stupor after months of abstinence.

TODAY'S TYPICAL alcoholic is a bright, middle-management executive in his thirties, married and living with his family. Only three percent are on skid row.

The alcoholic is no longer the drunk in the gutter. In 1956, according to the booklet, "the American Medical Association formally acknowledged that 'alcoholism must be regarded as within the purview of medical science'."

Alcoholism an Illness

The AMA and the American Bar Association termed alcoholism as an illness and that those suffering from the illness are entitled to the same rights and privileges in law and medical

THE DEPENDENT drinker will argue vehemently that he can cut it out with no difficulty then go to elaborate lengths to sneak a drink from hidden bottles.

treatment as are granted persons with other illnesses.

U. S. Senator Harold Hughes of Iowa, himself a recovered alcoholic, says this:

"If an employee suffers a heart attack, he is provided help by his company through insurance benefits and time off. Then, eventually, he is allowed to return on a part-time basis until recuperation is complete. The alcoholic, on the other hand, is usually fired."

Senator Hughes points out in "The Alcoholic American" that alcoholism is still the only disease where the patient is blamed when the treatment fails.

What causes alcoholism? What makes people—adult human beings—go from being a normal drinker to the alcohol-dependent drinker, and then to the alcoholic?

Disease is Progressive

The booklet points out that alcoholism is progressive. It is a slowly developing, progressive disease. There are no hard lines between each of the three stages.

The first real symptom, the booklet points out, is when a firm pattern of drinking has developed. The second warning signal is when the drinking in this established pattern increases.

There are many schools of thought on the causes of alcoholism. The booklet details many of them, but sums up that "it is a complicated illness which can be identified as one part physical, one part psychological, one part sociological and one part alcohol."

Warning Signals Listed

There are warning signs, red flags waving before the drinking American. If he only looks for them! Here is what "The Alcoholic American" tells the reader to think about:

Did you once have one or two drinks to relax after a long day, but now have three or four?

Do you find increasing pleasure in drinking at lunch?

Did you once drink to be sociable or to celebrate, and now drink to sleep or because you are worried or depressed?

Are you drinking more now than a year ago?

Do you drink now before you go to a party as well as during one?

The booklet points out that if you can answer "yes" to any of these warning signals, you are progressing beyond the "normal" drinking pattern. "At this point, alcohol is starting to take over, and the individual is beginning to lose control."

This is one of the critical points. The person "believes that he drinks because he enjoys it, when in fact he drinks because he wants it. And eventually he will be drinking because he needs it."

"The Alcoholic American" features a number of interviews with recovered alcoholics. Here is an example:

"I blamed everybody and everything for my drinking. I kept pointing the accusing finger at my job, my family, the abrasive life in the city, and everything except myself.

"You have to remember that I was not an alcoholic in the sense that I couldn't function. It was just that I drank every day and drank too much until it became a regular part of my life. And then my life became irregular.

"You see, even when a person gets to the point where alcohol has become too important, he still doesn't want to quit because everyone he knows drinks. He wishes he could maybe at least control it, but finds out it just isn't possible..."

The booklet doesn't condemn drinking. It advocates individual responsibility whereby the individual must "be ruthlessly honest" about his own drinking. This is how it's done:

If he drinks every day, he must ask himself why, where, and how much. Could he quit for two weeks at a time? And if so, what is his response to total abstinence—did he notice any anxieties because of the lack of alcohol?

Myths Exploded

Myths about drinking abound. "The Alcoholic American" explodes many of them. Here are just a few:

Myth: Women hardly ever become alcoholics. Fact: Actually, there are nearly as many women as men who are alcoholic. They just aren't exposed to as much public view.

TOO MANY TIMES, the dried-out alcoholic drinks himself into a stupo after months of abstinence.

Myth: If you can hold your liquor, you'll never become an alcoholic. Fact: To the contrary. This is the person who is lulled into a false sense of security. He doesn't know what is happening to him, but his liver does!

Myth: You can't become an alcoholic on beer alone. Fact: Many reformed alcoholics say that was all they ever drank! The fact is most American beers contain about 4½ per cent alcohol. It is just more diluted than the straight spirits!

Those who don't think all this talk about booze and what it can do to a person has any bearing on them personally must consider this fact: One in every fifty cars on the highway today is operated by a drunk driver. "The Alcoholic American" states that "the possibility of coming into contact with alcohol abuse is considerable."

Individual copies of the highly acclaimed Blue Shield booklet, "The Alcoholic American," are available without charge from the five Blue Cross Plans in the Commonwealth. Pennsylvanians are asked to write to the Blue Cross plan in their area.

ALCOHOLISM, defined as one part physical, one part psychological, one part sociological and one part alcohol, can happen to anyone who drinks.

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Council Outlines Program

Peer Review A Two-Way Street

Peer review activities guided by the Pennsylvania Medical Society take in a two-way street that provides the physician with traffic lanes for appeals, the Council on Medical Service points out.

The Council's description of peer review mechanisms was prompted by a Board of Trustees approval of a recommendation from the Society's new Interspecialty Committee which reported that many physicians were not aware that they had the right to appeal peer review decisions at several stages.

The Council points out that the goal of the program—to provide high health care at reasonable cost—is not one that serves just the interest of the public and third party carriers but is a key to the survival of non-government medical practice.

What, then, are the avenues open to a physician who disagrees with a peer review decision?

Robert P. Dutlinger, M.D., of Harrisburg, Chairman of the PMS Council on Medical Service, points out that the primary area where physicians may initiate reviews or appeal decisions is the one that affects them most directly—the review of the reasonableness of physicians' charges and of the utilization of physicians' services. Requests for such reviews may be initiated by the physician as well as by third party carriers and a physician who feels that a decision is unfair can appeal his case to his county medical society.

To place the avenues open to the physician in perspective, Dr. Dutlinger reviewed how the review mechanism came about in Pennsylvania: "The Pennsylvania Medical Society's peer review activities were initiated in Western Pennsylvania during the late 1950's as a result of the efforts of the Tenth Councilor District Medical Care Coordinating Committee under the chairmanship of Matthew Marshall, Jr., M.D., of Pittsburgh. The activities of the coordinating committee were the basis for the development of the Pennsylvania Medical Care Program approved by the State Society in the early 1960's. Provisions set forth in the Medical Care Program still serve as guidelines for expanding the Society's peer review activities under the direction of the PMS Council on Medical Service."

He pointed out the two separate functions of the review program:

First, the review of hospitalization cases to determine the propriety of of admissions and the appropriateness of the length of stay consistent with quality care.

Second, review of the reasonableness of physicians' charges and evaluation of any unusual uses—both as to type and number—of physicians' services.

Dr. Dutlinger noted that the primary responsibility for the first review function—hospitalization admissions and length of stay—is carried out by the medical staff's utilization committee of the individual hospital. This activity is supplemented by the PMS-Blue Cross Medical Advisory Committee. There are slight variations in procedure from one Blue Cross Plan to another but, fundamentally, the hospitalization review process begins with the selection of any questionable admissions and lengths of stay by Blue Cross in an internal review. Such cases may involve Blue Cross subscribers or government program beneficiaries and the cases, about which there are questions, are referred to the hospital utilization committee, the PMS Councilor District Review Committee, or county society review committees, depending on the procedure in the individual Blue Cross area. For example, in three Blue Cross Plans, the recommendation for hospital utilization committee are submitted to a medical advisory committee panel made up of representatives from several hospital staffs. The medical advisory committee panel is rotated for each meeting so that all hospitals with cases to be reviewed become involved in the process. In this hospitalization review area, the patient and the carrier are the ones with the direct stake in the decisions and the appeal right therefore rests with the patient who may use normal civil mechanisms.

'Goal of the program - to provide high health care at reasonable cost - is key to survival of non-government medical practice.'

Dr. Dutlinger said that the second review function—that involving evaluation of physicians' charges and use of services—is separate from the review of hospitalization cases. The physician review primarily is carried out by twelve State Society councilor district review committees, although four county societies have their own review committees, and by twenty-one PMS specialty advisory committees. The four counties with their own review committees are Cambria, Lackawanna, Northampton, and Philadelphia. The councilor district review committee members are appointed by county medical societies and the specialty advisory committee members, by organized specialty groups.

Physicians may initiate requests for review, Dr. Dutlinger pointed out, although he said most requests are generated by Blue Shield on behalf of their subscribers and those covered by government programs, by commercial insurance companies, and other third parties. The first review of the case—and often the only one—takes place before a councilor district review committee or, in the four counties mentioned, the county society review committee. These two types of committees have the option to render an opinion or refer the case to a specialty advisory committee. Dr. Dutlinger said most cases reviewed by the specialty advisory committees involve question about the degree or type of physicians services rendered.

Both the physician and the third party involved in a particular case may appeal an opinion by any of the three types of committees to the appropriate county medical society.

PENNSYLVANIA MEDICINE editorials

Cardiac Arrhythmias

Management Of Tachyrhythmias

The tachyrythmias may be divided into the atrial and ventricular varieties. In the setting of an acute myocardial infarction rate greater than 150 beats per minute may imply decreased coronary flow in inadequate cardiac output due to inadequate ventricular filling time. Hence, these mechanisms and especially those associated with the loss of atrial contribution should be terminated as promptly as possible. Classically, atrial tachycardia, flutter and fibrillation are initially treated with the intravenous digitalis. This agent may be administered intravenously—Cedilanid® (Sandoz), 0.4 mg., followed by another 0.4 mg. within 30 to 60 minutes. If the rhythm persists or signs of acute coronary insufficiency are present cardioversion is indicated. The patient may be sedated with Valium® (Roche), 5-10 mg. intravenously before delivery a precordial shock of 100-200 watt seconds to terminate the mechanism. It should be clearly stated however, that the tendency for recurrence of the dysrhythmia demands that the ultimate solution must be solved on a pharmacologic basis. Oral quinidine 200 to 300 mgs. or 100 mgs. intravenously every four hours or the combined use of propranalol 5-10 mgs. orally every 4 to 6 hours may be necessary to prevent the reemergence of the atrial arrhythmias.

Ventricular arrhythmias offer a more challenging situation. Ordinarily, ventricular premature beats are reduced or wiped out by the intravenous use of lidocaine. Fifty to 100 mgs. can be given intravenously followed by a lidocaine drip of 1-4 mgs. per minute. If ventricular premature systoles are still present, 300 mgs. of lidocaine is given in a bolus and 4-6 mgs. of lidocaine in an intravenous drip. Failure to control the arrhythmia with lidocaine under these circumstances leads one to add certain other pharmacologic agents such as a small dose of propanalol, not to exceed 1-2 mgs. every two hours in an intravenous drip. The addition of a third agent such as procainamide using 1-2 mgs. per minute in an intravenous drip may sometimes be required. One may approach the problem with intravenous procainamide using a bolus of 100-200 mgs. given extremely slowly intravenously followed by a procainamide drip of 1-4 mgs. per minute.

Failure to control ventricular arrhythmias under these circumstances should lead one to suspect that the precise mechanism of the arrhythmia may be something other than ordinary and an anti-fibillatory agent such as bretylium should be utilized. 300-600 mgs. given intramuscularly every six hours is sometimes required to prevent the recurrence of ventricular arrhythmias. It is important to discontinue the use of other antiarrhythmic agents when switching from group A to group B drug.

Ventricular tachycardia should be approached immediately with an intravenous bolus of lidocaine. If this fails to terminate and control the mechanism, precordial shock should be utilized. Pre-shock sedation with the use of 5-10 mgs. of Valium is required. Following precordial shock the recurrence of the rhythm must be controlled on a pharmacologic basis using intravenous lidocaine or procainamide.

The appearance of junctional tachycardia in the presence of acute myocardial infarction is often a challenging problem. These mechanisms usually resolve very rapidly and do not require a pharmacologic program. However, persistence of junctional tachycardia beyond several hours associated with inadequate cardiac output requires an approach much like ventricular tachycardia. Lidocaine and other group agents are administered as noted above.

Management Of Bradyrhythmias

Ordinarily, slow heart rates within the range of 50 to 60 beats per minute usually require no therapy whatsoever. In the setting of an acute myocardial infarction, these arrhythmias may predispose to ventricular ectopic beating. Rhythms below 50 beats per minute may also reduce the minute volume and produce inadequate cerebral blood flow as well as inadequate perfusion to the peripheral tissues. Hence, requirements for therapy or bradyrhythmias is both to enhance cardiac output and prevent the occurrence of more serious disturbances of cardiac rhythm including ventricular tachycardia and fibrillation.

When a sinus bradycardia develops in the setting of acute myocardial infarction, merely raising the foot of the bed may enhance venous return and accelerate the sinus rate. However, more often atropine 0.5 mg. to 1 mg. may be required to enhance the rhythmicity of the sinus pacemaker. This can be administered every one to two hours if necessary. It is important to keep the patient atropinized if there is a propensity to slowing of the sinus rate below 50 beats per minute. Occasionally, the infusion of isoproterenol 1 to 3 micrograms per minute may be necessary when atropine fails to enhance the sinus rate. In spite of these pharmacologic drugs slowing of the sinus rate below 50 beats per minute when the emergence of ventricular premature systoles of tachycardia may necessitate implantation of a temporary transvenous pacemaker.

Although it would be most ideal to pace the heart from the right atrium, it is frequently impossible to contain the catheter in a satisfactory position for long periods of time and ventricular pacing must then be utilized. It has been shown that rates above 70 beats per minute will enhance cardiac output as opposed to pacing rates below this level.

One does not necessarily resort to enhancement of the sinus activity or electrical pacing in the absence of clinical signs of inadequate cardiac output or premature systoles. A slow rate is sometimes beneficial within certain limits and should not be construed with a sinister prognosis.

Leonard S. Dreifus, M.D.
Hahnemann Medical College and Hospital
Philadelphia

Let George Say It:

Danger, Thin Ice

GEORGE A. ROWLAND, M.D.
Millville

When there is a wash-out on a public highway, the official caretakers must offer some type of protection to travelers. Among other alternatives there are two principal approaches open to them. First, if the situation requires only caution they may simply put up a sign that says, "DANGER, PROCEED WITH CARE." A more strenuous approach may be necessary if the road is really impassable. In that case, barriers may be set up with signs that say, "DANGER, ROAD IMPASSABLE, TURN BACK."

A third approach is possible but as far as I know is never used on the highways in our country. This would include the sign that says, "DANGER, FURTHER TRAVEL IS FORBIDDEN" and the stationing of sharpshooters at strategic points directed to shoot down any who are foolhardy enough to enter the proscribed area. Although this last technique is seldom used by the highway department, alert readers will recognize that it is applied in our narcotic laws. Since the use of drugs is considered so harmful to the human body, the convicted user of marijuana is subjected to a mandatory jail sentence of up to five years. Even if the drugs are not harmful, they are saying, this makes them so. This would seem to be an excellent way for keeping young people away from the danger of drugs, except for the fact that I recently heard a penologist state that it is absolutely impossible to keep drugs out of prisons.

This problem is not the purpose of this article, however. I am concerned with the chain across the road today. When the bridge has been swept away by the raging torrent and there is no possible way for a car to cross the river at that point, then an absolute barrier is indicated. Further travel on the road cannot lead to a safe destination. Drivers must be made fully aware of this fact even if they are careless and miss a road sign. Likewise, if the tablets contain lethal doses of cyanide, with death an immediate danger, it is not fair for us to let people debate the advisability of taking them. On the other hand, if the road is likely to become slippery when wet, or if the paving is merely a little bit irregular, travelers should be warned of the fact and told to proceed at their own risk.

If a medicine has both advantages and dangers, it should not be removed from the hands of those who have been trained to use it. It is extremely important that we keep in mind the advantages and the disadvantages of each therapeutic procedure, and do not discard some of our most valuable weapons because they may occasionally explode in our hands.

This is particularly true in cases like the recent ban of cyclamates as the result of a rather thoughtless item of legislation. Cyclamates were a valuable adjunct in the treatment of obesity which may be the cause of much shortening of life. It was decided to take this widely used substance totally off the market because very large doses of it has produced bladder tumors in rats. More recently, certain contraceptives were removed from druggists' shelves because they produced mammary fibromas in beagles.

It is my understanding that thalidomide, the drug that started all of our ultra-sensitivity to side effects was never found to produce fetal damage in any other species save man. Should the same situation arise again, all the animal tests we might do would not warn us in any way.

The extreme danger facing all scientific endeavor is that our meticulous experimentation with medications will undoubtedly discover some species that is harmed by each chemical. We will then put up our barriers to the use of aspirin, and penicillin, and each of the other valuable modalities that have been developed. Finally we will have walled ourselves off completely from all of the values of science. It has been suggested that the nuclear bomb might return civilization to the level of the cave man. It looks as though our scientific danger signs may accomplish the same thing slowly and quietly.

Wanted:

Communication, Not Rhetoric

Revolt, youth movements, the generation gap and the new society are all a part of the all too real problems confronting today's society.

According to a leading authority, Daniel Yankelovich, the results of two comprehensive studies of college students revealed that only 3 per cent of the student population are radical revolutionaries, the troublemakers. Forty-one per cent of the student population however, concur with the radical's diagnosis of what is wrong with American society, though they do not endorse revolutionary tactics.

When one compares 3 per cent to the 25 per cent of the population of the Thirteen Colonies actively supporting the American Revolution, today's conflict seems mild. Mr. Yankelovich points out, however, that a greater conflict is brewing between youth and business, rather than youth and the universities.

Today, youth is alienated from society, or against "the system," because of its continued minority group discrimination, its use of military and economic power in the exploitation of the people, the existence of institutions indifferent to the social needs of the people and because of the continued national prosperity while a large section of society continues to be in a desparate situation.

Very little can be done to change the minds of the hardcore radicals, but communication with the 41 per cent of the student population sharing the radical's beliefs and the 56 per cent desiring non-destructive reforms may have an ameliorative affect.

The communication must be two-directional, that is to and from the youth and the establishment. Open speech, open minds, facts and opinions must be exchanged. Internships providing youth the opportunity to take an active part in business and government exchange would seem beneficial.

Youth is skeptical and action-oriented—one can no longer rely on rhetoric to alleviate or explain away problems

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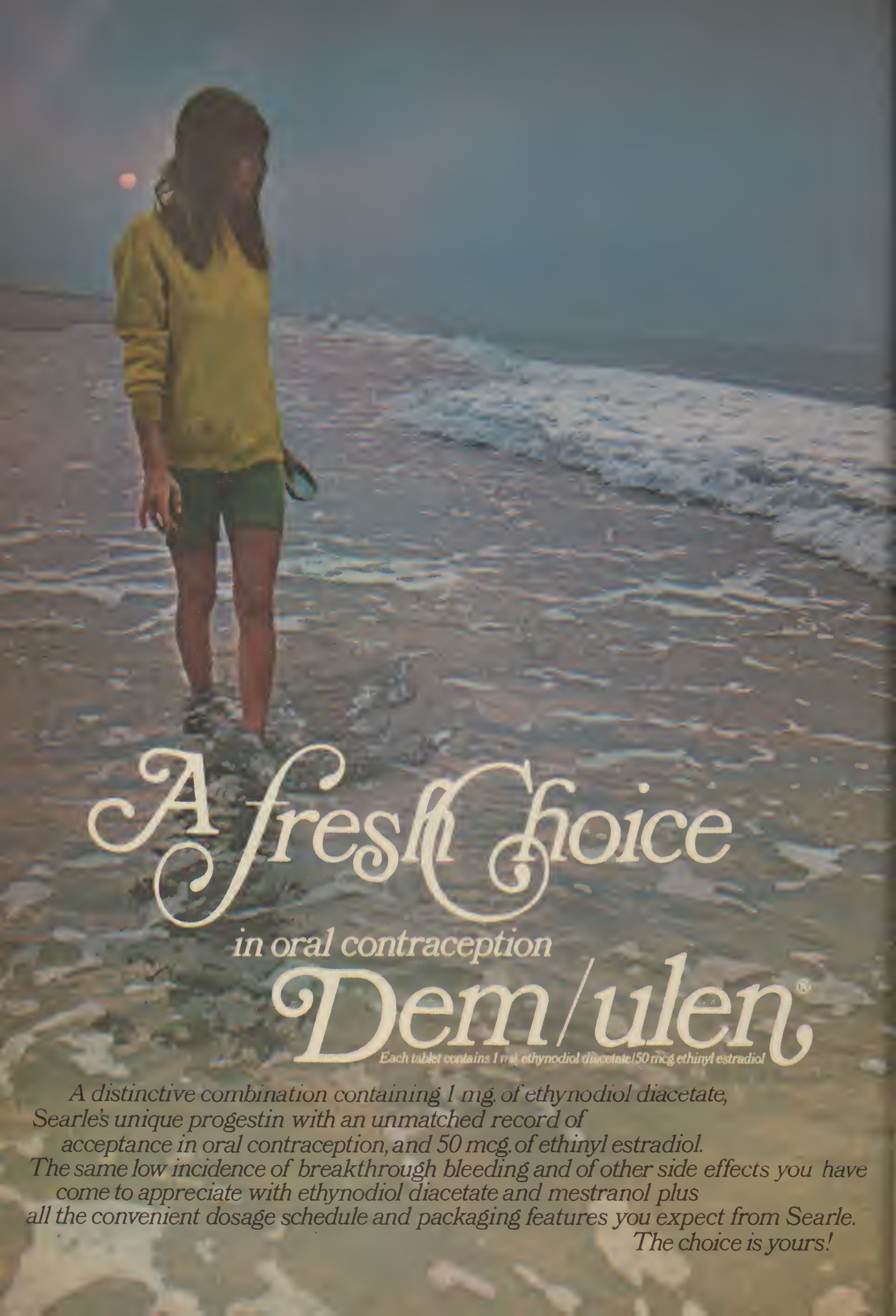

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Actions—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision. Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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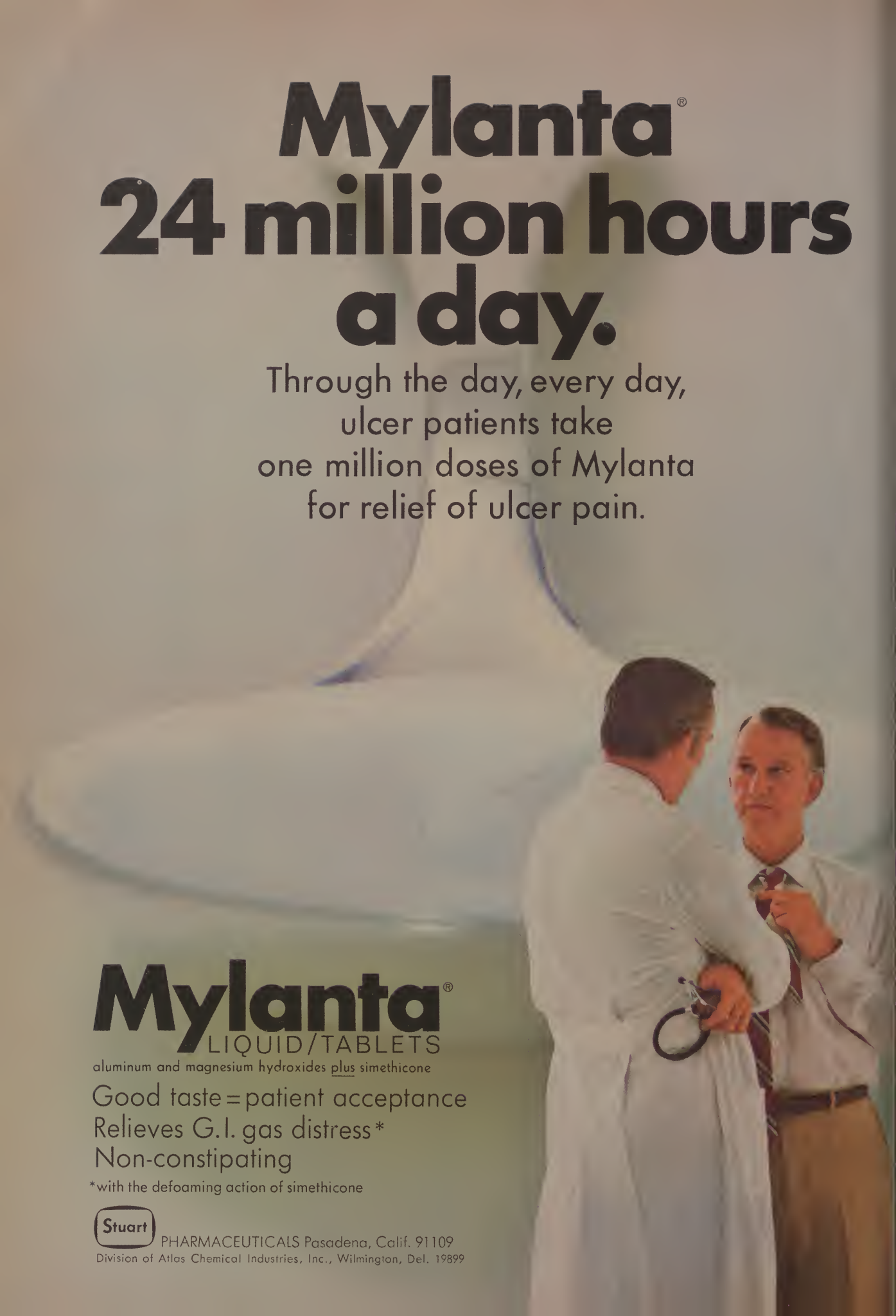

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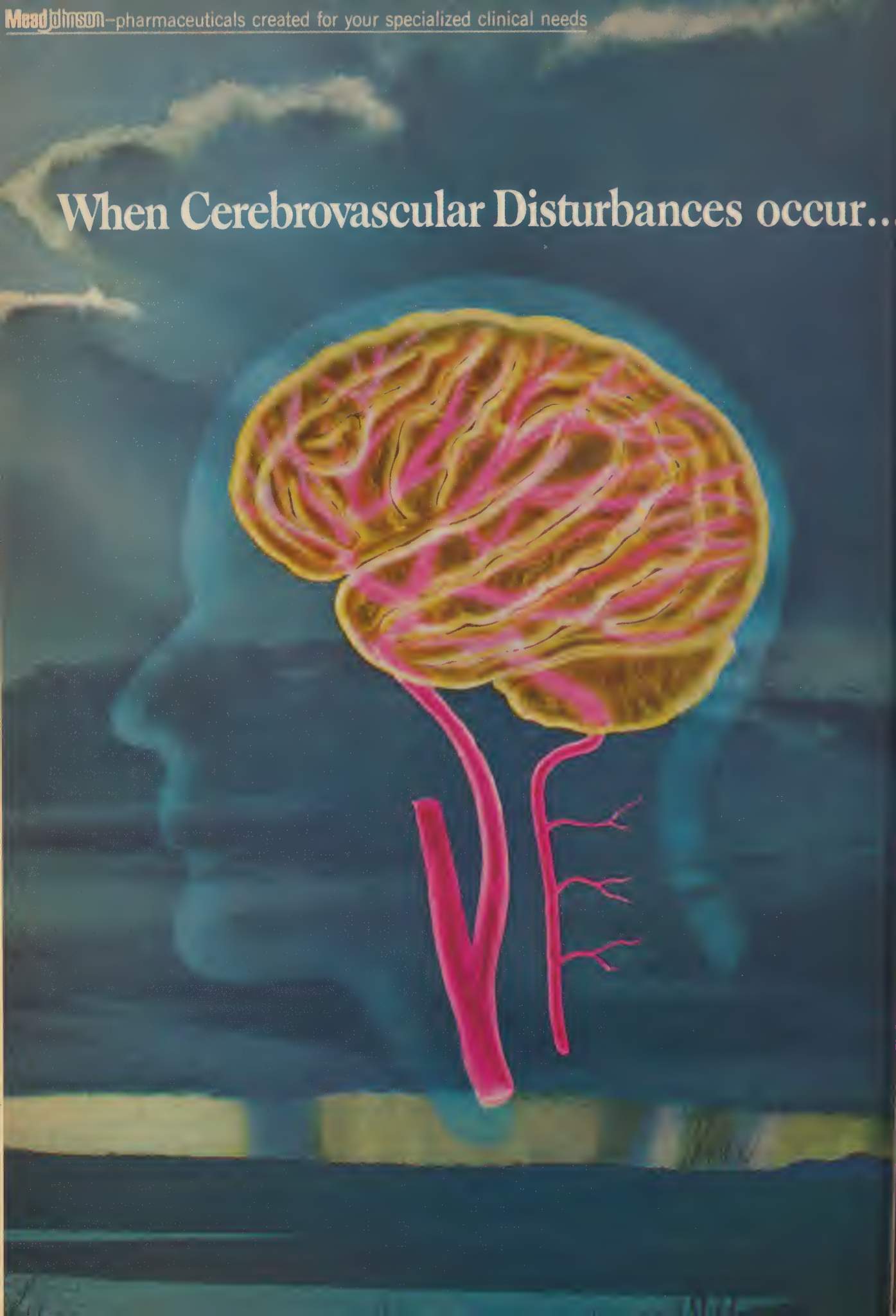

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Teaching Psychiatry Through Television

FELIX F. LOEB, M.D.

and

DONALD J. COLEMAN, M.D.

Pittsburgh

MANY TEACHING CENTERS are now using closed circuit television and videotape in their medical student and resident teaching programs.[1,6,7,8,9] Since the fall of 1967 we have been using these techniques as an adjunct to our teaching of medical students and residents at the University of Pittsburgh School of Medicine and Western Pennsylvania Psychiatric Institute and Clinic. We wish to discuss what we have learned from this experience. We will first consider some of the disadvantages and then some of the advantages of using these aids to teach junior medical students. Then we will discuss the use of this apparatus for teaching residents.

The junior clerks in psychiatry rotate through the clinical service with approximately nine to fourteen in a group for a six-week period. We teach them basic interviewing technique utilizing closed circuit TV and videotape during two one and one-half hour sessions per week. In the first session each week either the student or one of us interviews the patient in a studio-office while the others observe in another room. The patient is fully aware of the educational, research, and supervisory nature of the interview and has signed the release form. After the interview which is about thirty to forty minutes in length, the interviewer joins the rest of the group. Some questions are answered and the interviewer usually gives his general impressions about the interview and the patient. During the second session each week the taped interview is reexamined and relevant sections are viewed repeatedly.

Some of the disadvantages of this approach are as follows: The intervention of the TV device between the students and the patient reduces the students' immediate contact with the patient and may give them a less personal feeling toward the patient. Thus, the students may tend to watch the TV passively and with less involvement than they would a patient at a live interview. For example, at first the student will rarely ask for the taped material to be stopped. This lack of involvement is augmented by certain technical deficiencies, such as, occasional snow, blurring, lines, or an unsteady picture which may obscure the viewing. At other times the voices of the interviewing participants are muffled and unintelligible. At best it is usually not possible to see such nuances of facial expression as smiles, raised eyebrows, or eye blinks. For example, a patient we recently interviewed on television was smiling while tears rolled down her cheeks. Neither the smile nor the tears could be seen on the TV screen by the students.

At times the use of closed circuit TV and videotape creates such anxiety

within one or both participants that it is difficult to separate the patient's problem from his and/or the interviewer's discomfort about being observed and recorded.

We feel the advantages of TV outweigh the disadvantages. Our group of nine to fourteen students is too large for everyone to sit close around a patient and see and hear optimally. Even with its mechanical disadvantages, the television screen can be placed in a position where fourteen students can both see and hear reasonably well.

Having the students in a room separate from the patient being interviewed can also be an advantage. The students can ask questions and discuss the interview while it is in progress. Also, during the interview, a teacher can alert students to pay attention to significant interview behavior that they might otherwise fail to notice.

We feel that the chief advantage of the videotape is that it allows the students and teachers to repeatedly view the tape and to slow the tape down for slow motion viewing. Many aspects of an interview that we perceive and find relevant on the first or second viewing are not noticed by many of the students. Such aspects can be demonstrated to those students who had not observed them by going over the tape again. For example, one of us interviewed a paranoid schizophrenic patient on TV for the students. From the overall interview it became apparent to us and to some of the students that this patient confused himself, as an individual, with his brother. Certain students were able to point out to the rest of the group several of the patient's verbal statements which supported this idea. One of us noticed that whenever the patient referred to his brother with the personal pronoun *he*, the patient would say *hei* instead of he. The patient used a sound somewhere between that of an *E* and an *I*. It was necessary to replay the tape many times before all the students could hear this. This was concrete data that lent probability to the concepts of identity and disturbed ego boundaries.

One technique we have used is to move from an intuitive level to a cognitive level of processing data. We frequently observe a particular piece of gestural behavior exhibited by the patient. We stop the videotape and ask the students what they think is "going on in the patient's mind." Some students will quite literally repeat the words spoken by the patient. Other students will make an intuitive guess. For example, a young lady who was explaining the events leading up to her hospitalization said that she fired a blank gun knowing that the neighbors would wonder what was happening between her and her father. Embedded within "the neighbors would wonder" was a movement of her left leg. This movement both was a pulling away from the interviewer and a display of exposed thigh and buttock. Some students "guessed" that the patient was troubled "in her mind" about sexual fantasies. They were asked to find evidence in the tape to support their hypothesis. None could until the leg movement was pointed out to them. The students then noticed, on their own, that the patient made the same movement when she talked about her boy friend, about the grabbiness of men, and about her father.

'. . . the chief advantage of the videotapes is that it allows the students and teachers to repeatedly view the tape. We have found that watching the same tape many times is similar to seeing a patient in therapy over a series of interviews.'

We have found that watching the same tape many times has an effect similar to seeing a patient in therapy over a series of interviews. A psychotherapist working with a patient might require twenty or perhaps even fifty hours with a patient to observe some of the correlations between various of the behaviors of the patient (such as *hei* that we and the students were able to observe by watching parts of a single interview repeatedly. Thus the TV apparatus permits us to demonstrate to students, in a minimum of time, behavioral evidence of psychic determinism.

The use of closed circuit TV and videotape thus makes it easier to teach a scientific approach to clinical interviewing. Previously we would interview a patient in front of a group of students and then subsequently discuss the interview with them. If during the discussion we wanted to support a certain clinical interpretation with events from the interview, we had to rely on the student's ability to both register and subsequently recall these significant events. Students, of course, differed both in their ability to recognize and in their ability to remember relevant behavioral events. Whether the students failed to register relevant events because of lack of knowledge as to what was significant or because of their blind spots due to intrapsychic conflicts, these students had no basis for believing that we and teachers were basing our conclusions about the interview on observed behavior. This led some students to be either generally skeptical of psychiatric interpretations or else to gullibly accept them on faith in authority. With the videotape we do not need to depend upon the students' sensitivities, or their memories. Videotape permits us to go back over interviews and demonstrate to the satisfaction of all the students the actual behavior upon which we base our clinical generalizations.

We found that most junior medical students require a great deal of guidance during the first part of their six week course. We direct their attention to items relevant to the mental status. Such things as blocking, slips of the tongue, and defense mechanisms are pointed out. We have had to show them how to look and what sorts of things to look for. Their initial confusion is reminiscent of the confusion one experiences when first looking at

lls through a microscope. For example, we let the students watch the llowing behavior several times: a male patient pointed to her supra-bic region and said, "I do not ow what the feeling is, but it is a ortal sin." The students figured out at the feeling was and finally a student was able to wonder how the tient could not know and yet know. e group experienced some new in-ht into the meaning of "the uncon-ious" and its manifestations.

We have found that by the middle the six-week clerkship the students gin to enthusiastically observe for emselves. They draw inferences from at they see and then test these ferences by further observations of e videotape. As the students learn, eir inferences become more often rtinent.

'. . . by the middle of the six-week clerkship the students begin to enthusiastically observe for themselves.'

Some students who make reasonable ferences about the patient can list a rying number of actual behavioral ents in the interview which led them these inferences. Other students can ake equally reasonable inferences but e unable to remember behavioral ents from the interview to support eir inferences. A third type of student tends to make wild inferences ich have no basis in the observed terview material; their inferences are sed on things they have read or herwise learned.

Repeated viewing of the taped interew permits each of these three types students to learn. The first type of dent, who could support his clinical terpretations with memories of bevior, becomes delighted when he n find further data on the videotape support his hypothesis. The student o arrived at a reasonable inference t could not support it with memories behavioral events is pleased to find ch events and points them out to the oup when he sees the tape again. This lps him learn to seek and find evince for his suppositions. The student who made wild inferences is disappointed. He cannot find behavior on the tape to support his conjectures, and so he learns to base his inferences on behavioral data.

We have encouraged the students to make clinical hypotheses but have insisted that they support these hypotheses with actual behavioral data. We emphasize that, once an inference about a patient or about the interview situation has been shown to be supported by certain behavioral data, this does not prove the interpretation to be correct but only indicates that it is more or less probable. Once we have identified a probable interpretation, we ask students to predict from these probable interpretations what other behavior might be expected in the remainder of the interview. These predictive hypotheses are then tested by the students against the rest of the behavior in the taped interview.

We have run into certain problems with the videotape as a teaching device. We told our first group of junior medical students that as a matter of routine policy they would videotape one of their interviews with a patient and show part of it to the group. They were threatened. The group did not want to look at themselves; and, hence, the students had trouble learning. They did not get over this difficulty during their six-week experience. These students may have had trouble seeing themselves for some of the reasons Holzman[3,4] gives to explain why people have difficulty listening to their own voices. Students also seemed reluctant to remark about their fellow students' interviewing behavior, especially when such remarks might be deemed critical. The students rationalized the difficulty they were having by saying they could not learn how to interview by watching their fellow students interview because their fellow students did not know how to interview. They felt that, since we knew how to interview, we could show them how to do it well. Students defended against being seen on television in various ways. Some managed to get their patients to refuse to be interviewed. Others would sit unusually motionless and silent when in front of the TV camera. Still other students would arrange with their patients before the TV interview what they would and would not discuss. For example, they would agree to cover only certain parts of the history or they would agree not to talk about sex.

At first we also had difficulty watching ourselves on TV. We found it easier to watch the patient being interviewed than it was to watch ourselves interview. For this reason it has been easier with two of us working together. It is easier for each of us to see the other than to see himself. There are other reasons why it has been easier for two of us to teach than it would have been for one. When one of us is interviewing, the other can be with the students to answer questions or offer running commentary. When we subsequently go over a taped interview, one of us can work the controls to insure a technically good picture, while the other one can give his undivided attention to the interview itself.

Whereas, as mentioned, the students seemed to refrain from commenting on their fellow students' behavior during an interview, they were not so inhibited when commenting about our behavior. They enjoyed pointing out our self-revealing behavior especially when it was unintentional. Indeed, we have both learned new things about our own interview behavior.

After the first group of medical students, we stopped requiring them to videotape interviews. In retrospect, we and the students were much too anxious. With subsequent groups we left it optional whether we or the students

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or both interviewed the student's patients on TV.

Initially, we interviewed without first informing the students which diagnostic category of patient was to be presented. When we discussed such an interview, we found that the students had little to say. They had often not yet read anything about that particular clinical entity. We had to orient them and give them a general perspective to the problem. Under these circumstances we found that we did not have enough time during the allotted three hours per patient to adequately view the videotape a second time. Now we ask the students to tell us in advance what type of patient will be interviewed. We assign some reading material, and then the students get right to work.

For the past five months one of us has been supervising four residents who wanted to use the videotape within the traditional structure of a continuous case seminar. During the initial interviews the patients were told that approximately once every three or four weeks a session would take place in the studio office. All of the residents were surprised to see themselves carefully taking written notes during their taped interviews. They became aware of the defensive nature of their writing when they talked and joked about the fact that a "record" of the interview was on the tape.

One sees the learning alliance subject to all the vicissitudes that a supervisor comes to expect in any other supervisory situation. The residents' anxiety about learning is frequently expressed in terms of the patient's anxiety over the use of videotape. One example of this is now being seen within the work of one resident. In the early sessions the resident came to see (after repeated comments by his peers) what we have come to label as a "three step." This was a discernable, rhythmic sequence wherein the resident would ask a question, the patient would reply, and then the resident would make an interpretative and intellectual summary. This occurred repetitively throughout the interview. The resident defended his position but said that he would try to change. Several weeks later this same resident brought another taped interview to the seminar. There was a remarkable change in the quality, tempo, and content of this interview. The resident was listening and the patient seemed quite productive and active. It became apparent to the supervisor and some members of the group, however, that this resident would change the course of the interview whenever the patient brought up a certain theme. Both the supervisor and the group members pointed this out. The supervisor was thinking in three explanatory directions: the resident was experiencing a learning problem; the resident was merely suffering from lack of experience; the resident had some intrapsychic process that contributed to his behavior. The resident could not deny the interaction on the tape. He gave, however, only token recognition in an intellectual way.

The resident was not reliving the interview with the supervisor in the supervisory session. Not unexpectedly, this problem in the learning alliance quickly became reflected in the therapeutic alliance. The patient proposed that he talk about certain themes in the resident's office and other themes in the TV studio office. The resident agreed to this and rationalized his agreement by citing the patient's statement that the patient had recognized the TV technician as being an old neighbor. Here, one sees dynamic shifts within the learning alliance and the therapeutic alliance that are not new to supervisors nor to the literature. What is new is the use of televised interviews as a vehicle for observing such shifts.

After five months of supervising residents, one of us found that he shares neither Kubie's[8] enthusiasm for tapes in supervision nor Benedek and Fleming's[9] pessimism. One test of a working relationship between therapist and supervisor is the manner in which the therapist presents the data from previous therapeutic hours. In a good learning alliance the student-therapist can relive the therapeutic hours in the supervisory sessions. A replayed taped interview may facilitate this and can be thought of as a "stimulated recall" experiment. The student-therapist can be stimulated to varying degrees or may not be stimulated any more than he would have been by his notes. To remain the non-participant observer in the therapeutic alliance and the non-participant reporter in the learning alliance becomes increasingly difficult for a resident as he observes his own participation in the interview on tape. An example of the gratifying results that can occur when a resident allows himself to be stimulated by the taping is as follows: Recently during the replay of an interview, the supervisor noticed that the resident began to studiously write in his note-pad when the patient said that she could not talk to her classmates. She paused, made a fist, and went on to say that it "gets damn lonely." Another pause. The resident's head remained buried in his notes and he continued to write busily. It was enough for the supervisor to replay this segment twice. The resident saw on the last replay what he had not seen on the first two and what would have been impossible for him to observe during the interview. He went ahead affectively responding to the replay. He was stimulated to recall the patient's recent and pertinent early memories and then wondered out loud how he could be so competitive and frightened of such a needy girl.

As with teaching junior medical students, the supervisor of residents has only to point out what to look for and where to look for it. The use of TV seems especially advantageous in those cases where there is a lack of knowledge and a lack of experience. Even in those situations where the resident's character problems impair the learning alliance and impinges upon the therapeutic alliance the resident frequently is able to learn how to learn about psychotherapy as a process.

In summary, we feel that the use of videotape and closed circuit TV makes it easier for us to demonstrate specific vignettes of abnormal behavior to students. It also makes it possible for supervisor and therapist to observe the therapeutic alliance in action.

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Local Anti-rheumatic Effect Of Betamethasone

ALEXANDER M. MINNO, M.D.

Pittsburgh

THE intra-articular injection of betamethasone into arthritic joints is ollowed by decrease or disappearance f pain and swelling of the affected int. Adequate evidence is available iat cortisone exerts an anti-inflammaory action on many tissues affected y physical trauma, infection, chemical ritation, and hypersensitivity.[1,2]

Betamethasone used in this study a sterile aqueous suspension of etamethasone acetate and betamethaone alcohol as betamethasone diso-® ium phosphate (Celestone Soluspan, chering Corporation). The local therapeutic effects of betamethasone have een studied by Rothermich,[4] Roberts,[5] ohen,[7] Ottolenghi,[9] White[10] and Wyant.[11]

Since cortisone was introduced in 949, conflicting opinions have been ublished on the use of corticosteroids clinical medicine.[6] It soon became pparent that these substances proced often striking clinical improvement. However, arthritis is, in many istances, a chronic disease process hich is not self-limited. Therefore, ie management of rheumatic diseases ust be adapted to the changing eeds of each patient, the useful inical application of cortisone and ortisone analogues to intra-articular jections in patients with arthritic iseases was first introduced by Holnder et al.[3]

This report presents the results of ie local use of betamethasone in a oup of arthritic patients so that ractitioners can become more familiar ith this newer corticosteroid.

Patients with synovitis, usually resulting from an exacerbation of a joint were selected from the Arthritic Clinic of the Allegheny General Hospital or private practice. Over the years, more than 500 intra-articular injections of betamethasone phosphate-acetate mixture were given to patients ranging in age from 11 to 82, both male and female. Two long term results, one of degenerative joint disease in a 71 year old restaurant proprietor and the other of rheumatoid arthritis in a retired 73 year old bookkeeper was also tallied.

All patients were ambulatory. The joints injected were knees, ankles, metacarpal-phalangeal joints, proximal interphalangeal joints, shoulders, and hips. The greatest number of injections were into the knee.

In all instances pain was the primary indication for the use of betamethasone. In joints with effusion, aspiration was done as completely as possible before the injection of betamethasone intra-articularly.

All joints of all four extremities can be considered for intra-articular injection of betamethasone. The finger interphalangeal joints can be injected by using a 25 gauge needle and using the dorsomedial or dorsolateral approach. Multiple joints of the hand can be injected at the same time. The metacarpophalangeal and the metatarsophalangeal joints are frequent sites of injection. On the wrist the injection is made at the area of maximal tenderness of swelling and on the dorsal surface.

Effects on pain relief, stiffness, and swelling were observed. Patients were encouraged to maintain usual living patterns.

Joint symptoms varied from weeks to several years. All patients received adjunctive systemic therapy in the form of salicylates, analgesics, mild sedatives, and such specifics as chrysotherapy, phenylbutazone, indomethacin or adrenal corticosteroid therapy. Intra-articular injection of betamethasone is particularly useful when only one or two joints are actively involved or as an adjunct to other therapy. Repeated periodic injections effectively supported the patient in performing his usual daily activities.

The primary contraindication to intra-articular injections is the presence of infection in the joint or adjacent supporting tissue. Strict application of aseptic technique is important. Observation of this principle largely averts the chance introduction of infection into the joint itself. In this series there were no infections. A joint infection rate of less than 1 in 4,000 has been reported for more than 17,000 injections.[8] Although familiar with the history, one must rule out concurrent infection as a cause of inflammation in the joint, before administering corticosteroids intra-articularly.

Before administering, the skin is cleansed thoroughly. The area is sprayed with ethyl chloride (I prefer this) or infiltrated with procaine to prevent pain on insertion of the needle. Familiarity of the joint architecture aids in the proper positioning of the needle. A 21-gauge or smaller needle is rapidly inserted into the joint cavity. Once the joint capsule is entered, less pressure is required to advance the needle. A larger gauge needle is used for aspiration of joint fluid. When fluids are

not suspected, a 25 gauge needle can be used satisfactorily. The aqueous solubility of the betamethasone permits the use of a smaller 25 gauge needle.

The smaller needle produces far less pain and trauma to the soft tissue. Moreover, the intra-articular structures are better protected.

Results

Local pain at the injection site was minimal occurring mostly with the shoulder joint (five) and the others occurring at the various scattered joints. Local pain was transient, lasting from a few minutes to 15 minutes. All were able to dress themselves and leave the office without assistance. Pain relief was maintained in that effected secondary flares which may occur several hours after an intra-articular injection did not occur.

Pain relief can be rapid, especially in joints with effusion, but usually takes place within 2 hours and can last from one to four weeks or more. The beneficial effect and variability applies not only to individual patients but to the various joints in the same patient. When pain recurs, repeated injections can be used at intervals. This may vary from two to six or more weeks. There are relapses in some patients, so it is worthwhile to emphasize to the patient that the effect is only palliative to local inflammation and that repeated injections may be needed. The duration of benefit varies and often depends on the systemic involvement. Likewise, a joint that has been involved with the rheumatoid process for a long time will not respond as well as a joint that has not been involved previously or has been minimally involved.

The dosage varies depending on the size of the joint. In this study the largest amount per injection was 1.0cc (knee, shoulder or hip joint). In the smaller joints such as the interphalangeals (wrist or elbow) 0.25cc to 0.5cc appear to be adequate. In this study the shoulder joint appeared to be the least worthwhile joint to inject from the viewpoint of improvement.

In the patients with rheumatoid arthritic joint involvement, particularly of the knees, there appears to be a need for periodic injections at intervals of weeks or months and can have a steady but temporary benefit. Many have sufficient pain relief to eliminate the need for repeated local injection therapy although the rheumatoid arthritic process remains active. Conversely, in some patients local joint injection produced such a modest benefit that further injections did not seem indicated. This minimal result was often associated with functional psychological situations or a generally active disease process.

In this series 18 injections were classified as being of little or no help, although some beneficial effect is almost always achieved. In one instance the same joint, a knee with degenerative joint disease, was injected a second time with good but temporary relief in pain and stiffness.

Two representative cases of long term management with local intra-articular corticosteroid therapy follow:

Degenerative Joint Disease

P. J., a 71 year old obese restaurant owner-manager, was first seen on November 8, 1965, with the complaint of intermittent knee pain for two years. Two weeks prior to his visit, the pain in his knees became rather severe, handicapping his mobility. His personal physician prescribed oral corticosteroids, local heat to the knees and frequent non-weight bearing. There was little benefit with this procedure. His pain was always worse with initial movements and weight bearing.

Physical examination revealed a 5 feet 8½ inch tall 233 pound male. The skin over the legs had a reticular streaking pattern from the use of a heating pad. Pitting edema of a mild degree was noted over both lower shin areas up to the knee. Varicose veins of a mild degree were noted on the left leg. An effusion was present in the right knee with both knees displaying a flexion contracture of 15 to 20° and slight bilateral bowing of 20°. The blood pressure was 192/108 with remainder of the physical examination normal.

The x-ray examination of the right and left knees in the anterior posterior and lateral directions demonstrated narrowing of the medial half of the knee joints bilaterally with hypertrophic changes on the bones about the knees. There was also slight medial subluxation of both femurs on their respective tibias, with evidence of relaxation of the medial collateral ligament. The changes were more marked on the left than on the right. There was no evidence of a foreign body within either knee joint.

Beginning on November 8, 1965 the right knee was aspirated and betamethasone 1.0cc (6 mgm) injected at approximately 3 week intervals (5 injections with 20 to 30 cc clear yellow viscous fluid obtained each time) until January 7, 1966 when an effusion was noted in the left knee. At that time, aspiration revealed 10cc clear viscous fluid. 1.0cc betamethasone was injected into the left knee joint cavity. On April 11, 1966 his weight was 193 lbs. (a loss of 40 lbs. by voluntary dietary measures). His weight had stablized at this level ever since. The right and left knees have been aspirated and injected with betamethasone (1.0cc 6 mgm at approximately monthly intervals up to the time of this report 7/16/69). The left knee has been aspirated and injected with betamethasone 36 times with 5 to 10cc fluid obtained on April 5, 1967 with no fluid obtained since that date. The flexion contracture has been reduced to about 10 degrees. The right knee has been aspirated and injected with 1.0cc (6 mgm) of betamethasone 41 times with fluid obtained regularly in amounts of 15 to 30cc, until October 23, 1968 with intermittent fluid until February 12, 1969. No fluid has been obtained since that date. A flexion contracture of the right knee to about 15° remains. The present symptom of pain is relieved promptly after injection, i.e., within one half hour. The patient is fairly comfortable for 3 to 4 weeks. This gentlemen now works in his restaurant on a seven days a week schedule of 10 or more hours daily.

My opinion is that he has degenerative joint disease of the right and left knees with medial cartilage narrowing obesity and an intermittent stress elevated blood pressure (142/82 at present). With periodic injections of betamethasone he has been able to function fairly well in his usual activities of daily living (56 months).

Rheumatoid Arthritis

R.C., a 73 year old retired dairy office manager, was treated for arthralgias diagnosed as "chronic fibrositis" with the diagnosis changed to rheumatoid arthritis in May, 1960. He was treated with two courses of chrysotherapy with intermittent maintenance doses of salicylates, indomethacin, antimalarials and anaglesics. He has had pain and stiffness in many joint areas including the shoulders, ankles, knees, wrists, elbows and hands. He has continued to have pain in his knees on weight bearing, with particular difficulty on initial movements and stairs. He also complains of generalized stiffness of one to two hours each morn

ıg with return of pain for one to two ours late evening prior to retiring.

Physical examination revealed a an male with a weight of 174 lbs. ıd a height of 5 feet 10 inches. The eart was enlarged with the point of ıaximal intensity at the sixth inter-ɔstal space. The right elbow had exion contracture of about 35°. The ft shoulder had a loss of 30° external ɔtation, 20° of internal rotation, and loss of 15° elevation. The synovia ver the wrists, metacarpal and phalan-al joints was thickened and the ınds had an ulnar drift of about 15°. he right knee has a flexion con-acture of 15° and the left knee a exion contracture of 10°.

The other diagnoses include inactive ıodenal ulcer, chronic glomerulone-ıritis, arteriosclerotic heart disease, ırdiac enlargement AHC II B.

X-rays of the right and left knee owed minimal hypertrophic changes ɔut both knee joints in the form posterior marginal spurring along the ɔsterior surface of the patella. No her abnormality could be seen at ther knee joint. There was some sification in the region of the attach-ent of the patellar tendon to the ɔia bilaterally.

Beginning on May 2, 1962 periodic piration and injection of betameth-one 1.0cc (6 mgm) of the right and ft knee was instituted at intervals of ɔproximately four weeks. The right ıd left knees have been injected times. Clear viscous fluid in ıount of 10 to 50cc was obtained gularly from the left knee until ıgust 18, 1967 and on only two casions since. The right knee has d fluid in amount of 10 to 35cc gularly until December 3, 1968, termittent until April 7, 1969 with fluid obtained on three subsequent pirations.

As a rule, duration of pain relief ries from one to four weeks after jection. This time unpredictability pain relief is the usual pattern with eumatoid synovitis in contrast to at of the degenerative joint.

The pain relief from the aspiration fluid and injection of betameth-ɔne into the right and left knee has rmitted this gentleman to function rly satisfactorily. He has been receiv-; intra-articular knee injections with tamethasone on a periodic basis for months (a total of 81 injections o each knee).

Discussion

The need for local adjunctive therapy in addition to the usual therapy in rheumatic diseases is well accepted because of varied clinical manifestations. A newer corticosteroid, betamethasone has been developed for intra-articular use which has a marked and rapid local anti-inflammatory effect.

In my experience, the local injection of betamethasone in acute or persistent synovitis associated with degenerative joint disease is highly beneficial in inhibiting the inflammation and usually allows the joint to remain functional until some further activity induces a recurrence of inflammation and disability. I have found that the injections of betamethasone can be repeated many times. Flexion contractures of the knee can often be corrected with repeated local injections of betamethasone accompanied by a concurrent, vigorous physical therapy program. In some joints, the pain is relieved sufficiently so that further injections are not needed. Conversely, in some instances relief is brief and insufficient so that further injections were not given.

The pain relief afforded may give a false sense of security and allow the patient to over use the joint. Therefore, periodic joint x-rays and directions to the patient as to joint activity are recommended.

Summary

1. Injection of 0.25 to 1.0cc betamethasone into hundreds of painful joints produced a moderate to marked local improvement in symptoms which lasted from one week to months in a large majority of patients. This experience indicates that betamethasone is a highly active anti-inflammatory suspension for intra-articular injection.
2. The prolonged pain relief is prompt within minutes to 2 hours.
3. A small gauge needle (size 25) can be used in joints without evidence of an effusion and/or in smaller joints.
4. In instances of persistent joint pain, repeated injections at intervals have allowed patients to conduct daily activities in relative comfort. These intermittent injections can be given for years.
5. The adjunct use of local intra-articular therapy permits the rapid application of physical therapy measures.
6. Multiple joints, especially the smaller joints such as the phalangeals of the hand, can be injected at one sitting.
7. Local pain on injection was minimal and was probably avoided by the use of ethyl chloride spray. Any mild pain was of extremely short duration.

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Oral Contraceptive Agents And The Glucose Tolerance Problem

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AN ESTIMATED 8.5 million women in this country alone, and upward of 18 million women throughout the world, are taking one or another of the many available contraceptive agents. These substances are provided in a multiplicity of forms; however, all those marketed under the regulations of the United States Food and Drug Administration contain a progestogen and an estrogen. Reviews by Edgren and co-workers,[1] Maqueo-Topete and and associates,[2] Swyer,[3] Swyer and Little,[4] and Greenblatt and Rose[5] have adequately classified the progestogens in these compounds. Although a wide variety of progestogens are now in use, only two estrogenic compounds —mestranol and ethinyl estradiol, in varying doses—are employed. These substances may be administered in either sequential or nonsequential (combined) form, depending on the product and its particular purpose.

Despite the various approaches to contraceptive therapy and the large number of substances and combinations available, several questions as to the long term effects of these agents remain unanswered: (1) Does treatment with these substances interfere with carbohydrate tolerance? (2) What is the relation of such medication to thromboembolic phenomena? (3) To carcinoma?

Because adequate consideration of any of these as well as of other pertinent subjects might require a complete symposium, I shall limit my discussion to the problems involved with carbohydrate tolerance.

The question to be resolved is whether or not oral contraceptives induce glucose intolerance. Ingle[6] first reported the diabetogenic effect of diethylstilbestrol in the rat. Other investigators, such as Bangham and coworkers,[7] certainly have observed abnormal glucose tolerance in women under oral contraceptive medication. But is the incidence greater in these patients than that to be anticipated in a normal group of women observed over the same period of time? And how does such increase compare with the increased incidence observed in

pregnancy? Various investigators who see large numbers of diabetic patients state that they have not encountered either poor control or increase in insulin requirements during oral contraceptive medication. Banks[8] indicated that clinical intolerance to glucose is not a problem in patients receiving antifertility compounds. On the other hand, some observers believe that the use of the contraceptive steroids is associated with a higher incidence of glucose intolerance.[9-18] The mechanism, however, is unknown.

Data at hand

It is now realized that certain estrogens have an antagonistic effect on the peripheral action of insulin. DiPaola and co-workers[19] reported that the prednisone glucose tolerance test yielded abnormal findings for 66.7 per cent of patients under treatment with mestranol combined with norethisterone, whereas the results elicited in this test were abnormal for only 11.1 per cent of patients treated with an ethinyl estradiol-norethisterone combination. Apparently, the effect of estrogen on carbohydrate metabolism depends on the type of estrogenic substance used, as well as on the dosage and the individual characteristics of the patient under medication.

Comparisons also have been carried out with the progestogens. In general, however, these have yielded scant information, which either fails to implicate the progestational agents or suggests improvement in glucose tolerance after progestogen treatment. Spellacy[20] has reviewed these studies. The type of progestogen used also may be a factor since some of the progestogens partially metabolize to active estrogens.

Yen,[21] in an excellent review, has reported elevated human growth hormone (HGH) levels as well as high insulin levels in patients receiving ethinyl estradiol and dimethisterone (Oracon®, Mead Johnson) or ethynodiol diacetate and mestranol (Ovulen®, Searle). The peripheral anti-insulin effect of HGH also has been noted by Daughaday and Kipnis,[22] and by Rabinowitz and colleagues.[23] From the Yen study it might be inferred that the increased production of insulin balanced the production of HGH, and thus permitted a normal glucose tolerance.

Pregnancy has been discussed as an analogous situation, which is characterized by insulin resistance,[24] high insulin-like activity of the serum,[25] and destruction of insulin by the placenta.[26] There are obvious problems here in relation to interpretation of the oral versus the intravenous glucose tolerance test. In evaluating this whole concept, consideration also must be given to whether or not the diabetic patient requires insulin, oral hypoglycemic agents or diet alone. The brittleness of the clinical situation must be carefully assessed.

Discussion

Numerous reviews have suggested the problems to be anticipated in relation to the projected population explosion in future decades. The obvious requirements for living space, food and other factors now considered essential to modern life would emphasize that something must be done to curb the rapidly increasing size of our population. The presently available oral contraceptive agents offer one solution to the problem; they certainly are here to stay.

Now under way are massive research programs concerned with the so-called "microdose", in which only the pure progestational agents of one type or another are being tested in an effort to inhibit fertility by altering the cervical mucus, and perhaps other mechanisms. It is thought that fertilization and conception may be prevented by interfering with migration or capacitation of the sperm, or both, rather than by suppressing ovulation. Also under study for contraception in the female are injectable compounds that exert prolonged action, as well as a variety of intrauterine devices ranging from bows to rings.

Methods for inhibiting fertility in the male include ties and clips for the vas deferens; several other approaches are in various stages of experimentation. The long-used rubber barriers, such as condoms and diaphragms, also are widely employed.

None of these methods even approximate the efficacy of the oral contraceptives when these are consistently used as prescribed. The oral antifertility compounds are acceptable and convenient to the patient, and the over-all side effects do not deter more than 5 per cent of women from employing such medication.

Although some observers oppose the use of the oral contraceptive agents because of suspected alterations in carbohydrate metabolism, all the facts that represent each point of view must be put into proper perspective. Despite the elevation of insulin levels described in the Yen study,[21] and the

'The presently available oral contraceptive agents offer one solution . . . they certainly are here, to stay.'

increased production of HGH, the findings in the glucose tolerance test remained normal. One must consider that there is a potential here for depleting all pancreatic reserves of insulin, and that it is entirely possible to arrive at a state of glucose intolerance for which compensatory mechanisms are not available. However, only after well designed and controlled investigations are conducted in which (a) the various segments of the population are delineated and (b) the obese are separated from the slim; and in which (c) studies on pregnant patients are run side by side with others carried out on nonpregnant, nontreated patients, and those receiving oral contraceptives, will it be possible to reach a valid conclusion as to the metabolic effects of these compounds.

In addition, specific data are required concerning the alterations in carbohydrate metabolism attributable to each individual oral agent and its components, rather than broad generalizations about all. Many of the unfavorable findings reported were obtained in studies carried out on the early dosage forms of the norethynodrel-mestranol combinations (Enovid®, Searle) which contained larger amounts of estrogen than the agents now commonly employed.

A more recent study has been carried out by Boshell's group,[27] who confirmed the findings of others concerning the mild alterations in carbohydrate tolerance observed during oral contraceptive treatment. In their studies, Ovulen®(1 mg. ethynodiol diacetate plus 0.1 mg. mestranol) was administered on the day 5-25 schedule to a series of postmenopausal patients; and Ovral®, Wyeth (0.5 mg. norgestrel plus 0.05 mg. ethinyl estradiol), similarly to women of child-bearing age with an equal number of controls.

Ovulen produced, in the postmenopausal subjects, a significant degree of mild carbohydrate intolerance, which appeared not to progress or regress rapidly; but no important weight gain or elevation of fasting HGH levels, and no overt diabetes. A family history positive for diabetes was present in 40 per cent of those in whom glucose intolerance developed and in 44 per cent of those whose glucose tolerance remained normal during treatment.

Ovral, however, induced, in women during the reproductive period of life, no significant change in carbohydrate tolerance and no overt diabetes, although 2 controls and 3 of the treated patients had positive family histories. An unimportant, and so far unexplainable, increase in serum immuno-reactive insulin levels occurred in both controls and treated patients, but there was no significant change in either HGH or glucose levels.

The differences in glucose tolerance produced by the two oral contraceptives may have resulted from (a) the difference in type and dose of the estrogen component (0.1 mg. mestranol versus 0.05 mg. ethinyl estradiol), (b) the difference in type and dose of the progestogen (1 mg. ethynodiol diacetate versus 0.5 mg. norgestrel), or (c) the difference in ages of the two series of patients (average 49 years versus 23.9 years).

The time has come for science to prevail, with cessation of adverse comment written in loose terminology, which attributes undesirable characteristics of one specific compound to all others of a generally similar nature.

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There Is But One Medicine

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BENJAMIN Rush's statement, "There is but one medicine," is still very relevant, one hundred and fifty years later. Although veterinary medicine may seem distinct from human medicine, the disciplines are closely related. Information obtained from treating one species can be useful in treating another species. Such an example is the use of dilantin for epileptic dogs. In studying porphyria, research techniques have been greatly promoted by the fact that pigs also develop this disease.

In our specialty of dermatology, both human and veterinary physicians have much in common. This has been further emphasized during the past academic year, when we have visited one another's clinics. Both man and dog can itch and cause severe eczematization of their skin. Treatment is usually similar for both.

One of the major reservoirs of ringworm in man is the domestic animal. Nearly 80 per cent of the tinea corporis found in rural America is contacted from infected cows, horses, or pigs. In the urban setting, the percentage is much less; however, dogs and cats can harbor the fungi. As a result, the asymptomatic domestic animal can be the unknown carrier.

Recently, a family brought their Siamese kittens to the clinic because they had lost hair. Four weeks before, the mother cat had given birth to a large litter of kittens. One by one, each of the animals developed ringworm. Most had discrete patches of alopecia and crusting. One little kitten even had a kerion on her neck. Representative lesions were scraped. The scales were dissolved with 10 per cent KOH, and the slides examined under the high power of the microscope. Hyphae could be seen. The tentative diagnosis of tinea corporis was confirmed, when *Microsporun canis* was identified on the Sabouroud's media. The animals were given griseofulvin, and sodium tolnaftate (Tinactin, Schering) was applied to the larger lesions. Everything was well until the prolific mother cat gave birth to another litter. Within a few weeks, not only were the new kittens infected, but now the two children had developed skin lesions. These were scaling erythematous lesions with sharp margins, and they were scattered over the arms and abdomen. KOH scrapings and cultures confirmed the diagnosis of tinea corporis. Microsized griseofulvin at 5 mg/lb body weight was given for twenty days, and sodium tolnaftate was applied to the skin twice a day. This time the family was reminded to treat the mother cat and include her offsprings, too. To date, everyone is clear and well.

Although *M. canis* is not widely contagious, it can be highly so in some cases. Using simple therapeutics, a neighborhood epidemic can be prevented, and the animals saved. A well-meaning neighbor had suggested destroying the cats, and in the pre-

griseofulvin era, this might have been a necessity.

Another instance of veterinary and human dermatology interplay occurs in scabies. Although scabies may not be as prevalent as it once was, many lay people, as well as their physicians, have a low incidence of suspicion for this parasitic disease. In a period when there are numerous proprietary bath oils and lubricating creams, many people obtain a sufficient amount of relief from the itching. Thus, they seek no additional treatment for their skin. When the family dog begins to itch, they immediately seek professional advice. Many times the diagnosis in dogs is made quite readily. The animal has scratched away at his ears, nose, and abdomen, leaving crusted and erythematous lesions. A scraping of the lesion, when examined under the microscope, shows the adult parasite. The diagnosis of scabies is made. The animal is usually cured after one to two baths in gamma benzene hexachloride (Kwell, Reed & Carnrick). If the family is itching at the same time, it is a safe bet that they, too have the same disease. In man, scabies cause erythematous papular eruptions around the waist, on the chest when the animal may have been cuddled, and between the fingers. Diagnosis is confirmed by probing a burrow and seeing the mite; however, this is more difficult in man today, because of all the medicines he may have applied. The treatment involves a bath, followed by the application of gamma gamma benzene. The clothes should then be washed by machine in hot water. This should be the end of the infestation in this household. Occasionally, retreatment is necessary in four to seven days.

'Both disciplines can be helpful to one another by the variations in disease patterns.'

Both disciplines can be extremely helpful to one another by the variations in disease patterns. Dogs, like man, suffer from atopic dermatitis. Their treatment is complicated by the fact that topical steroids are extremely difficult to apply to a hairy area. On the other hand, dogs can be maintained on low doses of oral steroids for an indefinite period without any of the side effects which plague people, when taking such medicaments for even several weeks.

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Of particular interest to us have been seborrheic conditions. Seborrhea in domestic animals, and particularly dogs, is a common dermatologic problem and represents the vast majority of cutaneous ailments seen by the veterinarian. Man often has the typical oily secretions of the sebaceous glands, but we shampoo our scalps frequently. As a result, we do not notice this condition, unless it is marked. Then, a sulfur-salicylic acid shampoo (Sebulex, Westwood, Ionil, Owen), is helpful. The therapeutic secret is to allow the shampoo to stay on the scalp for a full five minutes, before washing it off. Similar treatments in dogs alleviate much of their problem. Seborrheic dermatitis, which differs from seborrhea, also occurs in both species. Whereas in the dog this can be on the nose, ears, back, and abdomen, in humans, the crusted, oily lesions are found on the scalp, preauricularly, on the glabella, in the axillae, on the sternum, and in groin. A shampoo, to which a tar derivative has been added (Sebutone, Westwood, Ionil-T, Owen, or Tersa-tar, Doak), corrects the condition in fairly short order. For the more severe case, steroid creams can be added. Valisone cream applied three times a day is very good, and in the hairy areas, a spray, (Aero-seb HC, Herbert Laboratories), works well.

Several important aspects now differ and have led us to wonder if following such avenues will not be highly significant. Dogs do not develop acne, yet they have highly active sebaceous glands. We do know that certain species of dogs, such as Cocker and Springer Spaniels, English Bulldogs, and Dachshunds, become highly seborrheic, yet all races of man develop acne, contrary to many older studies. There is a predilection in dogs for seborrhea from six to fifteen months and six to nine years, while in humans, acne and seborrheic dermatitis are most pronounced in the corresponding adolescent and middle age years. Although we have recently disproved most of the fables about acne by showing that chocolate does not cause flares, dogs on low fat diets have dandruff and oily secretions. These signs clear, when unsaturated fats are added to the diet. Dogs with low thyroid function, as shown by depressed PBI and T_3 uptake levels, also have a great deal of seborrhea. Although we presently do not believe that thyroid function is related to acne and seborrhea dermatitis, perhaps we will eventually have more sophisticated methods which will show certain abnormalities.

Environment And The Heart

ving Imber, M.D., questions William . Leaman, Jr., M.D., Fellow, Council n Clinical Cardiology of the American eart Association, Unionville, Pennylvania.

hy is a discussion of the environent so important in the manageent of heart disease?

Today, in the presence of so many ore "dramatic" drugs and procedures, ıysician and patient alike often tend overlook the simple features afcting the management of the cardiac ıtient. The influence of environment one of these.

hat environmental features may cause ıncern?

Extremes of weather in various eas, increasing pollution of the air ıd its diminishing oxygen content, rcadian dysrhythmia (rapid transit time zones in a jet age) are all ctors to be considered in the prence of heart disease.

hat are the cardiac effects of rapid ıanges in heat and humidity?

About three-quarters of America is ɔt to be hot and humid during mmer months. This type of weather poorly tolerated by patients with ırdiac disease, as evidenced by inease in dyspnea and chest pains. This particularly prevalent among those ffering from congestive failure or ıose recovering from recent myoırdial infarction. Respiratory infecons at this time also put a strain on ıe heart.

ow do sudden changes in the weather ffect the cardiac patient?

Sudden changes place an excessive ork load on the circulation. The heart te generally increases in an attempt to aintain a thermal balance. Death rates llowing acute myocardial infarction crease when temperatures and humidy are high. There is also an increase in this complication during the winter months, particularly in northern cities. Sudden exposure to cold air or unaccustomed exertion, such as snow shoveling, may upset a previously well balanced coronary system.

What environmental pollutants adversely affect the heart?

Automobile exhaust and smoke from many factory and civilian chimneys are most often responsible. For instance, in December, 1952, England suffered a severe cold spell which increased fuel consumption. A high atmospheric pressure pushed down the smog and the result was 4000 deaths, mostly cardiac and pulmonary. Airplane exhausts must also be included here. Even a reduced, but long-continued, air pollution may hasten the development of emphysema and subsequent heart failure.

How is it possible at the present time to handle the problems of heat, high humidity and smog and improve the treatment of the cardiac patient?

All cardiac patients, particularly those in the older age groups, should be specifically informed regarding the potential dangers of heat, humidity and smog, which affects almost every major city and many smaller ones in the world today. All outdoor activities should be individually scheduled in order to avoid the hot and humid daytime hours, and, whenever possible, air conditioning should be used. Appropriate adjustments in fluid intake and diet should also be made.

What about anoxia secondary to high-altitude air travel?

As a result of improved control methods today, anoxia from this source is rare since most air lines provide additional oxygen and a uniformly stabilized air pressure in their cabins.

Does traveling quickly from a hot, humid environment to a cooler climate place an added burden on a diseased heart?

Yes. Sufficient time should always be allowed to adjust to the change before permitting increased physical activity. The first day in the new location should never be devoted to extensive activities (even sight seeing). Altitude readings should also be considered and adjustments made accordingly.

Is there any additional advice we should give a cardiac patient contemplating a sudden climatic change?

Proper electrolyte and fluid balances need attention. Rent and frequent smaller meals are preferable if a satisfactory cardiovascular adjustment is expected.

What effects do a sudden change in the time zones have on a cardiac patient?

If more than three to four time zones are quickly crossed, motion sickness, emotional depression, marked fatigue and minor gastrointestinal disorders may appear. Even though these symptoms may be fewer in seasoned travelers, it is always good practice to advise cardiac patients to obtain more rest before undertaking a long air journey. Should circadian dysrhymia occur, its management is mainly supportive since the effect of a quick crossing of many time zones is nearly always transient and self limiting. Only rarely will such energetic treatment as fluid and electrolyte replacement be required. A mild sedative may be necessary in some instances. Above all, operation of an automobile on the day of arrival is not advised. An intelligent planning of the itinerary will contribute a great deal in preventing the difficulties of adjustment to a different time zone.

William G. Leaman, Jr., M.D. prepared this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.

Don't Let Them Go Home In The Dark

Some years ago a skilled editorialist coined the above phrase referring to the dying patient. For the cancer victim it is especially apt and poignantly true.

While no physician likes to be defeated by disease, people do die. There comes a time, all too often, when surgery, radiation and chemotherapy can no longer control the cancer. This end point may be scientifically difficult to define but the personal physician, with his intimate knowledge of the patient and family, usually has little trouble recognizing the situation. At this time the patient needs, more than ever, guidance and support for the awesome experience of deterioration and death. The aid given in attempting to help them live must be matched by helping them to die.

Specific symptoms usually present no major problems. Weakness is the most common complaint and responds reasonably well to androgens and corticosteroids. Pain is not present in many advanced cancers. When it is, control by narcotics of sufficient potency and amount is indicated. Certainly addiction is of no concern at this stage. In only a few instances does intractable pain require nerve section or chemical blockade.

The many other symptoms, nausea, cough, diarrhea, constipation, depression, etc. are handled attentively. If nursing care is not a great problem and the family and patient are willing, home care is the best environment. Otherwise an extended care facility is preferable.

Most important are the patient's psychological needs. Especially he must be made to feel he will not be abandoned or forgotten. Family and religious support are vital and medical support is crucial. Visits must be maintained at the usual frequency, perhaps even increased in number if the patient is aware and desirous of such help. The patient's family also needs medical support in the form of progress reports and simple explanations of problems. Attentive and compassionate care are of the greatest value. For truly no one should have to go home in the dark.

CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, The Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.

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GENERAL MEDICINE

quippa-Rochester Hosps. (rotation); third Wed., ea. mo.

oona Hospital; fourth Thurs. ea. mo.

eensburg (Westmoreland Hosp.); first Tues. ea. mo.

nstown (Conemaugh Valley Mem. Hosp.); first Thurs., ea. mo.

trona Heights (Allegheny Valley Hosp.); second Tues. ea. mo.

iontown Hospital; last Mon. ea. mo.

shington Hospital; first Wed. ea. mo.

O/I—DIAGNOSIS AND MANAGEMENT HYPERTENSION; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin P. Shapiro, D., Project Dir., 501 Flannery Bldg., 30 Forbes Ave., Pittsburgh 15213.

entown; September 2, 1970—May 5, 1971
I—TEAM APPROACH TO PATIENT RE (Fall-Winter Education Program); at red Heart Hosp.; first Wed. ea. mo.; rs. each day; AAGP credit applied for. ntact Vincent J. Jerant, M.D., Chm. use Staff & Educ., Sacred Heart Hosp., & Chew Sts., Allentown 18103.

oona Hospital; October 15, 1970—May 1971
I/AMA—A PROGRAM OF CONTINUG MEDICAL EDUCATION; by Jefferson Penn State; every other Thurs,; 7 nths; 30 hrs. AAGP credit approved. ntact John H. Killough, Ph.D., M.D., oc. Dean, Jefferson, 1025 Walnut St., ladelphia 19107.

hlehem; September 17, 1970—May 20, 71
I/AMA—A PROGRAM OF CONTINUG MEDICAL EDUCATION; by Jefferson Penn State; at St. Luke's Hosp.; third urs. ea. mo. (except December); 8 mos.; GP approval requested. Contact John H. lough, Ph.D., M.D., Assoc. Dean, Jefferon, 1025 Walnut St., Philadelphia 19107.

dford/Kane; October 20, 1970—May 20, 71
I—CURRENT MEDICAL AND SURGIL CONCEPTS (A Pennsylvania Medical ntinuing Education Program); by CES; ernately at Bradford's Penn Hills Club Kane Manor; third Tues. ea. mo.; 18 . AAGP credit applied for; $25 fee ($5 gle session). Contact CES, Pennsylvania dical Society, 20 Erford Road, Lemoyne 043.

ester; September 8, 1970—May 25, 1971
I/AMA—POSTGRADUATE SEMINARS FOR PHYSICIANS; by Hahnemann; at Crozer-Chester Med. Center; 2 hrs. AAGP credit approved ea. day; 38 days; a day ea. week. Contact James E. Clark, M.D., Chief of Med., Crozer-Chester Med. Center, 15th & Upland Sts., Upland, Chester 19013.

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Pitt—University of Pittsburgh, School of Medicine
Pitt P.H.—University of Pittsburgh, Graduate School of Public Health
Penn State—Pennsylvania State University
Temple—Temple University Health Sciences Center
U. of Pa.—University of Pennsylvania, School of Medicine
Woman's—The Medical College of Philadelphia

DuBois Hospital; February 4—April 8, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Thurs.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

East Stroudsburg; October 17, 1970—April 17, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at General Hosp. of Monroe Co., third Sat. ea. mo., (except December); 18 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Erie; September 17-18, 1970—May 13-14, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Vincent's Hosp.; Thurs. eve. and Fri. morn.; approx. once every three weeks; 39 hrs. AAGP credit applied for. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Gettysburg; January 12—April 21, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at Annie Warner Hosp.; alternating Tues. and Wed. every other week; 24 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Hazelton State Gen. Hosp.; September 2, 1970—May 26, 1971
I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hazelton Branch of Luzerne Co. Med. Soc., and Hosp.; 1½ hrs. per day; 1 day per week; 36 weeks; 30 hrs. AAGP credit. Contact Robert L. Gunderson, M.D., Dir. of Med. Educ., Hazelton State Gen. Hosp., Hazleton, Pa. 18201.

Johnstown; November 24, 1970—May 25, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Conemaugh Valley Memorial Hosp., fourth Tues. ea. mo. (except Jan.); 6 sessions, 2 hrs. ea.; 12 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lancaster General Hosp.; September 22, 1970—May 18, 1971
I—CONTINUING MEDICAL EDUCATION PROGRAM; 1 day ea. week; 18 weeks; 3 hrs. AAGP credit applied for ea. session. Contact John H. Esbenshade, Jr., M.D., Dir. of Medical Educ., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17601.

Lancaster Osteopathic Hosp.; October 8, 1970—March 11, 1971
I/AMA—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; 16 Thursdays; 2 hrs. ea. day; Contact Harold F. White, D.O., Chmn., Prg. Comm., Lancaster Hosp., 1100 E. Orange St., Lancaster 17602.

Lebanon; November 3, 1970—May 4, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Quentin Riding Academy; first Tues. every other month; AAGP credit requested. Contact John Killough, Ph.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lewistown Hospital; February 10—April 14, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Wed., ea. mo.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Lock Haven Hospital; October 21, 1970—May 5, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP

credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Meadville; September 2, 1970—May 5, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first Wed. ea. mo. at Spencer Hospital; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Philadelphia; September 14, 1970—May 17, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Methodist Hosp.; first and third Mon. ea. mo. (except holidays); AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Philadelphia; January 5, 1970—February 2, 1971
I/AMA—ROLE OF THE PRIMARY PHYSICIAN IN THE TREATMENT OF PATIENTS REQUIRING SURGERY; by Jefferson; at room 207, Jefferson Hall; 10 hrs. AAGP credit approved; Contact John H. Killough, M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Pottsville; September 24, 1970—May 27, 1971
I/AMA—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; at Good Samaritan Hosp.; fourth Thurs. ea. mo. (except Nov., Dec. and Apr.); 2 hrs. ea. day. Contact Norman M. Wall, M.D., Dir. of Med. Educ., Good Samaritan Hosp., E. Norwegian and Tremont Sts., Pottsville, 17901.

Pottsville Hospital; September 3, 1970—June 3, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; first Thurs. ea. mo.; 10 mos.; 2 hrs. AAGP credit approved per session. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

Reading; September 22, 1970—May 25, 1971
I—1970-71 CONTINUING EDUCATION PROGRAM; at St. Joseph's Hosp.; fourth Tues. ea. mo. (except December); 8 hrs. AAGP credit requested. Contact Kenneth M. Schreck, M.D., Med. Dir., St. Joseph's Hosp., 215 Walnut St., Reading 19603.

Sayre; August 24, 1970—June 14, 1971
I—ROTATING SEMINARS (10 sessions Cardiology; 5 sessions Dermatology; 11 sessions Endocrinology; 13 sessions Hematology; 7 sessions Neurology; 8 sessions Psychiatry; 4 sessions Radiation Therapy; 9 sessions Urology—Nephrology); at Robert Packer Hosp.; 1 hr. ea. session; hour-for-hour AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., Dir. Med. Educ., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Scranton; October 21, 1970—May 19, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Mercy Hosp.; 1 day a month; 8 months; 24 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Sellersville; September 23, 1970—June 16, 1971
I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann and Grandview Hosp.; at Grandview Hosp.; fourth Wed. ea. mo. (except December); 18 hrs. AAGP credit requested. Contact D. Henry Ruth, M.D., Dir. of Med. Educ., Grandview Hosp., Sellersville 18960.

Sharon General Hospital; October 21, 1970—April 7, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES: first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Somerset Community Hospital; October 14, 1970—May 12, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; second Wed. ea. mo. except Jan. & Feb.; 18 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

St. Marys; October 25, 1970—February 28, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program) by Educational and Scientific Trust of PMS; at St. Marys Country Club; fourth Sunday ea. mo. (except December); 12 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Tunkhannock; March 17—May 19, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program) by Educational and Scientific Trust of PMS; at Tyler Memorial Hospital; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Uniontown Hospital; October 14, 1970—March 24, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every other Wed., (except December); 30 AAGP credit applied for. $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wellsboro; March 17—May 19, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Soldiers & Sailors Hosp.; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wilkes-Barre General Hospital; September 17, 1970—April 15, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; third Thurs. ea. mo.; 8 mos.; 3 hrs. AAGP credit approved for ea. session. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Williamsport Hosp.; September 11, 1970—March 12, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; second Fri. ea. mo. (except January); AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

INTERNAL MEDICINE

York Hospital; September 17, 1970—April 29, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every Thurs.; 30 weeks; 3 hrs. AAGP credit approved ea. day; $40 fee ($8.00 single session). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Philadelphia; October 14, 1970—May 12, 1971
I/AMA—INTERNAL MEDICINE REVIEWS; by Hahnemann; at Alumni Hall; 3 hrs. a day; 1 day a week; 27 weeks; $150 fee ($70 per subspecialty); 81 hrs. AAGP credit approved. Contact Wilbur A. Oaks, M.D., Prog. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

MALIGNANT DISEASE

Philadelphia; September 9, 1970—June 23, 1971
I—CANCER DETECTION IN OFFICE PRACTICE; at American Oncologic Hosp.; 4 hrs. a day; 1 day a wk.; 20 hrs. AAGP credit approved; course repeated every 5 weeks. Contact Joseph G. Strawitz, M.D., Assoc. Dir., American Oncologic Hosp., Central & Shelmire Aves., Philadelphia 19111.

MICROBIOLOGY & IMMUNOLOGY

Allentown Hosp.; September 10, 1970—June 10, 1971
I—IMMUNOLOGY: BASIC CONCEPTS-CLINICAL APPLICATIONS (A Program of Continuing Medical Education; by Jefferson and Penn State; second Thurs. ea. mo.; 10 mos., 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc., Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

Danville; September 16, 1970—May 19, 1971
I—PSYCHIATRY AND COMMUNITY MENTAL HEALTH; by The Institute of Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. ea. day; 1 day a wk.; 10 weeks; 20 hrs. AAGP credit applied for. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Danville; September 24, 1970—May 27, 1971
I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. per day; 1 day a week; 20 weeks; 40 hrs. AAGP credit applied for $25 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster Gen. Hosp.; September—November, 1970 and February—April, 1971
I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; 2 hrs. ea. day, 1 day ea. week; 20 weeks ea. semester; 40 hrs. AAGP credit applied for; $25 fee ea. semester. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139

orristown; March—May, 1971
I—THE LATENCY AGE CHILD: by The nstitute of the Pennsylvania Hosp.; at lontgomery Co. Mental Health Clinics, nc.; 2 hr. a day; 1 day a week; 8 weeks; 6 hrs. AAGP credit applied for; $50 fee. ontact J. Martin Myers, M.D., Psychiatrist-i-Chief, Pennsylvania Hosp., 111 N. 49th t., Philadelphia 19139.

lorristown State Hospital; March 5, 1971—lay 21, 1971
I/S—FAMILY THERAPY; by Norristown tate Hospital; 2 hrs. each day; one day ach week; 10 weeks; $50 fee. Contact ohn D. Pruitt, M.D., Dir. Cont. Educ. for sychiatrists, Norristown State Hospital, tanbridge and Sterigere Sts., Norristown 9401.

hiladelphia; October 8, 1970—April 6, 1971
I—MEDICAL HYPNOSIS; by the Insti-ite of the Pennsylvania Hosp. and U. of Pa., iv. of Grad. Med.; at The Institute; 4 hrs. a ay; 1 day a week; 20 weeks; 80 hrs. AAGP edit applied for; $150 fee. Contact J. artin Myers, M.D., Psychiatrist-in-Chief, ennsylvania Hosp., 111 N. 49th St., Phila-elphia 19139.

hiladelphia; October 14, 1970—March 3, 971
I/AMA—PSYCHIATRIC PROBLEMS OF HILDREN; at Hahnemann; every Wed. xcept holidays); 18 weeks; 36 hrs. AAGP edit requested; $75 fee. Contact Paul J. ink, M.D., Dir. of Psych. Educ., Hahne-ann, 230 N. Broad St., Philadelphia 19102.

hiladelphia; October 21, 1970—June 2, 971
I/AMA—SEMINARS IN PSYCHOTHER-PY; SHORT-TERM, CRISIS AND SUP-ORTIVE THERAPIES; at Hahnemann; hree 10-week seminars; every Wed.; 20 hrs. a. seminar; AAGP credit requested; $75 fee or 10-week session, $150 for 30 sessions. ontact Paul J. Fink, M.D., Dir. Psych. Educ., ahnemann, 230 N. Broad St., Philadelphia 9102.

hiladelphia; January 7—March 25, 1971
I—TECHNIQUES OF CURRENT THER-PY IN THE MANAGEMENT OF MARI-AL PROBLEMS, ADOLESCENT PROB-EMS AND CHRONIC COMPLAINERS; t The Institute of Penna. Hosp.; 3 hrs. a ay; 1 day a week; 12 weeks; 36 hrs. AAGP edit applied for; $50 fee. Contact J. lartin Myers, M.D., Psychiatrist-in-Chief, ennsylvania Hosp., 111 N. 49th St., Phila-elphia 19139.

hiladelphia; February 23—March 30, 1971
I/TREATING TODAY'S ADOLESCENT; y Institute of Pa. Hosp. of U. of Pa.; at The nstitute; 1½ hrs. a day; 1 day per week; weeks. Fee $50. Contact J. Margolis, M.D., oordinator, Institute of Pa. Hosp., 111 N. 9th St., Philadelphia 19139.

hiladelphia; February 23—April 27, 1971
I/TREATING SEXUAL INCOMPATI-ILITY; by Institute of Pa. Hosp. and). of Pa.; at Marriage Council of Philadelphia; ½ hrs. a day; 1 day per week; 10 weeks. ee $50. Contact Gerald J. Margolis, M.D., oordinator, Institute of Pa. Hosp., 111 N. 9th St., Philadelphia 19139.

hiladelphia; February 22—March 29, 1971
I/PSYCHOPHARMACOLOGY; by Insti-ute of Pa. Hosp. and Dept. of Psych. of). of Pa.; at 111 N. 49th St.; 2 hrs. a day; day a week; 6 weeks. Fee $50. Contact erald J. Margolis, M.D., Coordinator, Insti-tute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; April 7—May 12, 1971
I/AMA—DRUGS: PSYCHOTROPIC, PSYCHEDELIC AND ADDICTING; at Hahnemann; every Wed.; 6 weeks; 12 hrs. AAGP credit requested; $50 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; March 24—May 26, 1971
I/AMA—ADOLESCENCE AND THE YOUTH CULTURE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 10 hrs. AAGP credit requested; $75 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CONTINUOUS COURSES

Sessions of the following courses will convene continuously until completed.

ANESTHESIOLOGY

May 27—29, 1971; Pittsburgh
C/LIFE SUPPORT-MAJOR ORGAN SYSTEM FAILURES (Fifth Annual Symposium on Acute Medicine) by Amer. Soc. of Anesthesiologists; at Pittsburgh Hilton; $100 fee. Contact Bulent Kirimli, M.D., c/o Dept. of Anesthes., V.A. Hosp., Pittsburgh 15240.

CARDIOVASCULAR DISEASE

May 6—7, 1971; Pittsburgh
C/PRE-INFARCTION PATIENT; by Pa. Heart Assoc.; at Chatham Center; 7 hrs. ea. day; 14 hrs. AAGP credit applied for; $25 fee. Contact Royce J. Britton, Prg. Dir., Pa. Heart Assoc., P.O. Box 2435, Harrisburg 17105.

CHEST DISEASES

January 31, 1971; Charleston, W. Va.
C—FOURTH ANNUAL MID-WINTER CONFERENCE ON CHEST DISEASE (A symposium on Air Pollution); by W. Va. State Medical Assoc.; at Daniel Boone Hotel; 5 hrs. Contact Joseph T. Skaggs, M.D., Co-chairman, P.O. Box 1031, Charleston 25324.

March 1-12, 1971; Philadelphia
PG—POSTGRADUATE COURSES IN BRONCHOESOPHAGOLOGY; at Temple, Contact Charles M. Norris, M.D., Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

ENDOCRINOLOGY

March 10, 1971; Sharon
C/AMA—MEDICAL AND SURGICAL ASPECTS OF THYROID DISEASE: by Jefferson and Penn State; 3 hrs. AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

FORENSIC MEDICINE

March 1971; Berks Co. Med. Soc., Reading
April 14, 1971; William Penn Hotel, Pittsburgh
May 1971; Conemaugh Valley Mem. Hosp., Johnstown
June 1971; Lehigh Valley Club, Allentown
O—MALPRACTICE IN THE EMERGENCY ROOM; by CES; 3 hrs. AAGP credit $5 fee. Contact Comm. on Emerg. Med. Serv., Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pa. 17043.

GENERAL MEDICINE

April 3, 1971; Harrisburg
C—DIABETES; by CES and Pa. Osteopathic Assoc.; at Holiday Inn Town; 6 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

OBSTETRICS & GYNECOLOGY

April 15, 1971; Hershey Motor Lodge
C—12TH ANNUAL MATERNAL & CHILD HEALTH INSTITUTE; by CES and Pa. Dept. of Health; $10 fee; 4 hrs. AAGP credit applied for. Contact Comm. on Maternal & Child Health, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

OPHTHALMOLOGY

April 28-30, 1971; Pittsburgh
C/S—OPHTHALMOLOGIC MICRO-SURGERY; by Pitt; at Eye and Ear Hospital; 24 hrs.; $400 fee. 20 limit. Contact Kenneth T. Richardson, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

May 5-7, 1971; Pittsburgh
C/S—STRABISMUS (A Comprehensive Symposium in Diagnosis and Treatment); by Pitt; at Eye and Ear Hospital; 24 hrs.; $200 fee; 20 limit. Contact David A. Hiles, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

OTOLARYNGOLOGY

April 1-2, 1971; Philadelphia
C/AMA—THERAPY IN OTOLARYNGOLOGY; 1971 (Postgraduate symposium); by Jefferson; $50 fee ($10 to residents). includes luncheon both days and one dinner. Contact William Baltzell, M.D., Dept. of Otol., Jefferson, 1025 Walnut St., Philadelphia 19107.

PUBLIC HEALTH & PREVENTIVE MEDICINE

June 23, 1971; University Park
C—SPORTS MEDICINE CONFERENCE; by CES and Penn State. Contact CES, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

new members

These M.D. s have joined the State Society in recent months:

BEAVER COUNTY:

H. Ronald Leapman, M.D., 2102 Darlington Rd., Beaver Falls 15010.
John P. Thomas, M.D., 315 Connecticut Ave., Rochester 15074.
Carol F. Thel, M.D., 1404 Brodhead Rd., Aliquippa 15001.

BRADFORD COUNTY:

Robert W. Ridley, M.D., 104 Rosh Rd., Sayre 18840.

BUCKS COUNTY:

Donald F. Nase, M.D., Pennridge Medical Arts Bldg., Sellersville 18960.
Jack Spivack, M.D., 44 Sweetbriar Lane, Levittown 19055.

DAUPHIN COUNTY:

Malcom H. McGavran, M.D., M. S. Hershey College of Medicine, Hershey 17033.
William W. Resinger, M.D., 2736-B Green St., Harrisburg 17110.
Harry J. Suter, M.D., 3514 Trindle Rd., Camp Hill 17011.

DELAWARE COUNTY:

Francis A. Breen, Jr., M.D., 308 Mt. Alverno Rd., Media 19063.
Donald H. Cook, M.D., Pathology Dept., Lankenau Hospital, Philadelphia 19151.
Leonardo Dishman, M.D., MCMC Fitzgerald Div., Darby 19023.
Harold T. Dodds, M.D., 148 David Dr., Havertown 19083.
Jeffery M. Greene, M.D., 1815 Earlington Rd., Havertown 19083.
Pasquale B. Guarini, M.D., 382 Avon Rd., Upper Darby 19082.
Joseph H. Magee, M.D., 330 N. Princeton Ave., Swarthmore 19081.
Gerald A. Melchiode, M.D., 275 S. 19th St., Philadelphia 19103.
Peter V. Palena, M.D., Media Clinic, Providence and Beatty Rds., Media 19063.
Edith M. Plagata, M.D., 163 Rambling Way, Springfield 19064.
Neil I. Silverman, M.D., 1439 Upland St., Chester 19013.

FAYETTE COUNTY:

Roldan G. Medina, M.D., 205 East St., Uniontown 15401.

PHILADELPHIA COUNTY:

Jean L. Forest, M.D., 546 W. Queen Lane, Philadelphia 19144.
Richard F. Limoges, M.D., Medical College of Pennsylvania, Res. 71, Philadelphia 19129.
Jorge A. Montero, M.D., 2 Schiller Ave., Penn Valley 19082.

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meetings

FEBRUARY

Twentieth Annual Scientific Session of the American College of Cardiology, February 3-7, 1971, Sheraton-Park and Shoreham Hotels, Washington, D.C. For information and registration contact: William D. Nelligan, Executive Director, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014.

Twenty-Third Annual Program of the Academy of Forensic Sciences, February 21-26, 1971, Del Web's Towne House, Phoenix, Ariz.

MARCH

Society for Cryosurgery meeting, March 1-5, 1971. Diplomat Hotel and Country Club, Hollywood, Fla. Direct inquiries to: Secretary, Society for Cryosurgery, 30 N. Michigan Ave., Chicago, Ill. 60602.

Jefferson Medical College of Thomas Jefferson University presents a postgraduate symposium on the "Therapy in Otolaryngology—1971," March 25-26, 1971, Philadelphia. For information contact: General Chairman, William H. Baltzell, M.D., Department of Otolarngology, Jefferson Medical College, 1025 Walnut St., Philadelphia, 19107.

obituaries

○ *Indicates membership in the Pennsylvania Medical Society at time of death.*

○ Harvey R. Bauman, Coopersburg; efferson Medical College, 1923; age 3; died October 4, 1970. No survivors re listed.

○ John L. Bowers, Beach Haven Terrace, N.J.: Temple University School of Medicine, 1940; age 60; died October 14, 1970. Dr. Bowers had been general practitioner in Reading until is retirement in 1967. Surviving are is wife, a son and a daughter.

○ Henry G. Bregenser, Pittsburgh; University of Pittsburgh School of Medicine, 1931; age 64; died October , 1970. He is survived by his wife nd a son.

○ Leo P. Sheedy, Pittsburgh; George Washington University School of Medicine, 1933; age 62; died Septmber 2, 1970. He was a former presilent of the Allegheny County Medical Society. His wife, two sons and three laughters survive.

○ James A. Seligmann, Wynnevood; Hahnemann Medical College, 1929; age 68; died September 15, 1970. He was a member of the staff of Bryn Mawr Hospital and had practiced n Wynnewood for more than twenty ears. Surviving are his wife, two sons nd two daughters.

○ William W. Dyer, Bryn Mawr; University of Pennsylvania School of Medicine, 1932; age 64; died Septemer 14, 1970. He was a specialist n internal medicine and executive lirector of the College of Physicians f Philadelphia. His wife and two ons survive.

○ Richard G. Oakley, Johnstown; University of Pittsburgh School of Medicine, 1944; age 49; died August 9, 1970. He was a former chief of nedical service at Memorial Hospital. Surviving are his wife and three sons.

○ Richard M. Thorpe, Pittsburgh; University of Pittsburgh School of Medicine, 1960; age 35; died Septemer 19, 1970. An ophthalmologist, he erved on the staff of Montefiore Hospital and the Eye and Ear Hospital n Pittsburgh. His wife and a son urvive.

○ James E. Van Glider, Wilmingon, Delaware; Jefferson Medical Colege, 1912; age 80; died August 20, 970. A son survives.

○ G. Harlan Wells, Philadelphia; Hahnemann Medical College, 1902; age 90; died August 28, 1970. He was a former chief of medical services at Philadelphia General Hospital and a past president of the American Institute of Homeopathy. Survivors include his wife, a son and two daughters.

○ John H. Abbott, Allentown; Hahnemann Medical College, 1940; age 68; died September 18, 1970. A practicing physician for thirty years, he was also active in developing the Alcoholics Anonymous program in the community. He is survived by his wife and four sons.

○ Enoch H. Adams, Bellefonte, Johns Hopkins University School of Medicine, 1919; age 80; died September 6, 1970. Until his retirement in 1959, Dr. Adams had served as chief of staff of the Centre County Hospital. Surviving are his wife and two daughters.

○ William J. Connelly, Miami, Fla.; University of Pittsburgh School of Medicine, 1911; age 86; died September 13, 1970. His wife and a daughter survive.

○ Jacob L. Gluchoff, Bloomsburg; Temple University School of Medicine, 1938; age 58; died September 14, 1970. During World War II he had served in the U.S. Army Medical Corps. Survivors include his wife, a son, a daughter and a brother.

○ Dorsey R. Hoyt, Indiana; Jefferson Medical College, 1934; age 65, died August 28, 1970. He served as a member of the U.S. Army Medical Corps during World War II. He specialized in ophthalmology and otolaryngology and served as president of the Indiana County Medical Society. He is survived by his wife and a son.

Joseph F. Hoffman, Exeter; Jefferson Medical College, 1932; age 62; died September 17, 1970. He is survived by his wife, two sons and four daughters.

Clara M.C. Astley, Pittsburgh; Medical College of Pennsylvania, 1904; age 88; died September 23, 1970. Dr. Astley served as president of the board of managers of the Hospital of the Medical College of Pennsylvania, and played an important role in the merging of the Hospital of the Medical College of Pennsylvania with the Hospital of the University of Pennsylvania. She is survived by a daughter and two sons, one of whom is Royden Astley, M.D.

○ Charles Rupp, Jr., Philadelphia; Harvard Medical School, 1933; age 61; died September 1, 1970. He served as the chief of the department of neurology and psychiatry at Lankenau Hospital, and as an associate professor of neurology at the University of Pennsylvania's School of Medicine. His wife survives.

Brenton C. Burgoyne, Philadelphia; Bowman Gray Medical School of Wake Forest University, 1964; age 32; died October 24, 1970. He is survived by his wife, Elsmer Smith Burgoyne, M.D. a resident in dermatology at the University of Pennsylvania Hospital.

Arthur G. Denman, Downingtown; Hahnemann Medical College and Hospital, 1946; age 49; died May 14, 1970. His wife survives.

Domenic M. Pescatore, Philadelphia; Middlesex University School of Medicine, 1937: age 63; died October 20, 1970. He was a senior physician at the Fernald State School until his retirement in 1968. Surviving are his sister and three brothers.

Edward C. Thomas, Upper Darby; Jefferson Medical College, 1926; age 70; died October 10, 1970. He was a retired Naval medical officer with the Bureau of Medicine and Surgery and the Veterans Board of Appeals. Survivors include his wife, a brother and a sister.

Carl A. Tobias, Scranton; Jefferson Medical College, 1943; age 53; died October 15, 1970. He had served as assistant chief of the Scranton clinic of the Tuberculosis Society, as physician in charge of the Well Baby Clinic and as deputy coroner. His wife and four daughters survive.

Jessie Wright, Royal Oak, Md.; University of Pittsburgh School of Medicine, 1934; age 70; died September 6, 1970. Dr. Wright was widely recognized for her work in combating infantile paralysis and rehabilitating its victims. Dr. Wright developed the fast-rocking bed to reduce the patient's stay in an iron lung, and at the D.T. Watson Home for Crippled Children in Leetsdale, she served as chief of staff and assisted Jonas Salk, M.D., in developing the polio vaccine. She was named Pittsburgh's Woman of the Year in 1950, and in 1962 was named a Distinguished Daughter of Pennsylvania. No survivors are listed.

PENNSYLVANIA MEDICINE classified

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Emergency department physician—M.D. or D.O. Pa. registered. Modern JCAH accredited hospital in process of merger and large expansion program. Fourth physician needed to round out current staff of three to cover round the clock. Excellent financial and fringe benefits. Administrator, Lewistown Hospital, Lewistown, Pa. 17044.

Board certified anesthesiologist for 270-bed hospital. Fee for service. Active OB department. Night call in hospital. Give details first letter. Apply Director, Department of Anesthesia, Lower Bucks Hospital, Bristol, Pa. 19007.

Radiologist—Board certified or eligible. Immediate opening in 230-bed general hospital. Active, expanding x-ray dept. 35 miles west of Philadelphia. Salary negotiable. Contact J. James Cancelmo, Jr., M.D., Coatesville Hospital, 300 Strode Ave., Coatesville, Pa. 19320, or call (215) MU 8-5102 after 6:30 p.m.

Wanted—Psychiatrists for Mental Hygiene Clinic operated within 951-bed modern neuropsychiatric hospital; immediate opening at salary range $22,918-$25,538; general practitioners interested in psychiatry welcomed; excellent working conditions in active cultural center and university affiliation; liberal fringe benefits; non-discrimination in employment. Write: Hospital Director, VA Hospital, Leech Farm Road, Pittsburgh, Pa. 15206, or call collect (412) 362-2000, ext 208 or 209.

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Physician—For general medical work at accredited state mental hospital—full or part time. Two separate county units and one geriatric infirmary unit. Assist with medical treatment and care of 560 patients. Pennsylvania license required. Salary—full time $17,839 - $20,629, part time $15,387 - $20,629. Superintendent, Dixmont State Hospital, Sewickley, Pa. 15143.

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any equivalent combination of ex-
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The director of Hazelwood's Primary Care Station would receive an appropriate culty appointment at the University of Pittsburgh School of Medicine and ould participate in the hospital's patient care, teaching and community rvice programs.

For additional information please write or call:

David Segel, M.D., Director of Ambulatory Services
Montefiore Hospital
Fifth At Darragh
Pittsburgh, Pa. 15213
(412) 683-1100 Ext. 208

14TH ANNUAL CONVENTION
PENNSYLVANIA ASSOCIATION OF MEDICAL ASSISTANTS
CHATHAM CENTER, PITTSBURGH
MAY 13-16, 1971

HOSTED BY
ALLEGHENY COUNTY CHAPTER
of
PENNSYLVANIA ASSOCIATION OF MEDICAL ASSISTANTS

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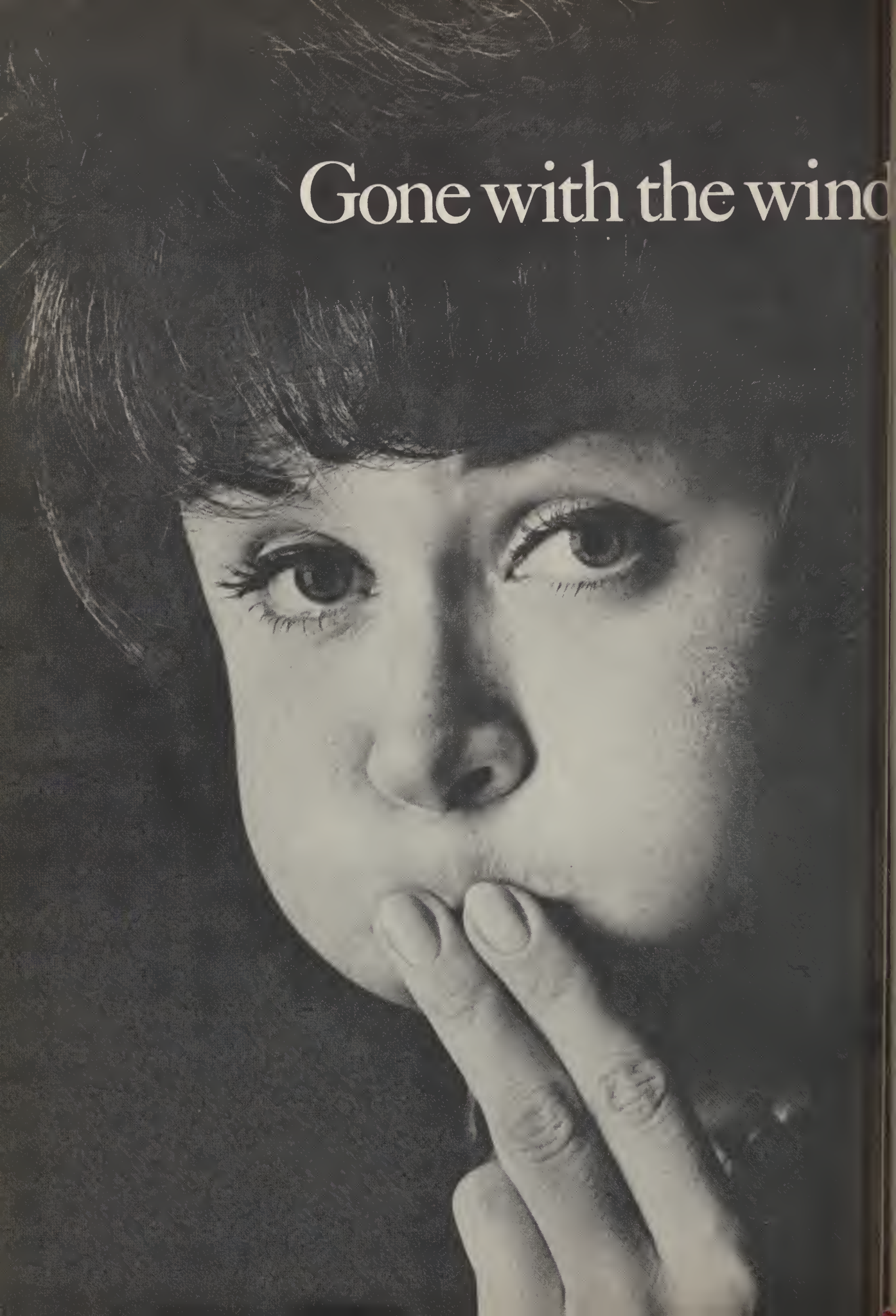
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*Langer, A.: Med. Times *94*:150 (Feb.) 1966.

Announcing the "Antgasid"

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Tablets: simethicone plus aluminum hydroxide/magnesium carbonate co-dried gel and magnesium hydroxide
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One dose does both: frees captured gas...neutralizes free acid

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THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522

ANTROCOL®

Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.

Each tablet or capsule contains: Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

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DOSAGE: One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

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in severe systemic infections—postoperative bacteremia, Gram-negative/staph pneumonias or neonatal sepsis—Kantrex® (kanamycin sulfate) is often indicated before results of customary sensitivity tests can be reported. Clinical response is often seen within 24-48 hours in susceptible infections, with remission soon after.

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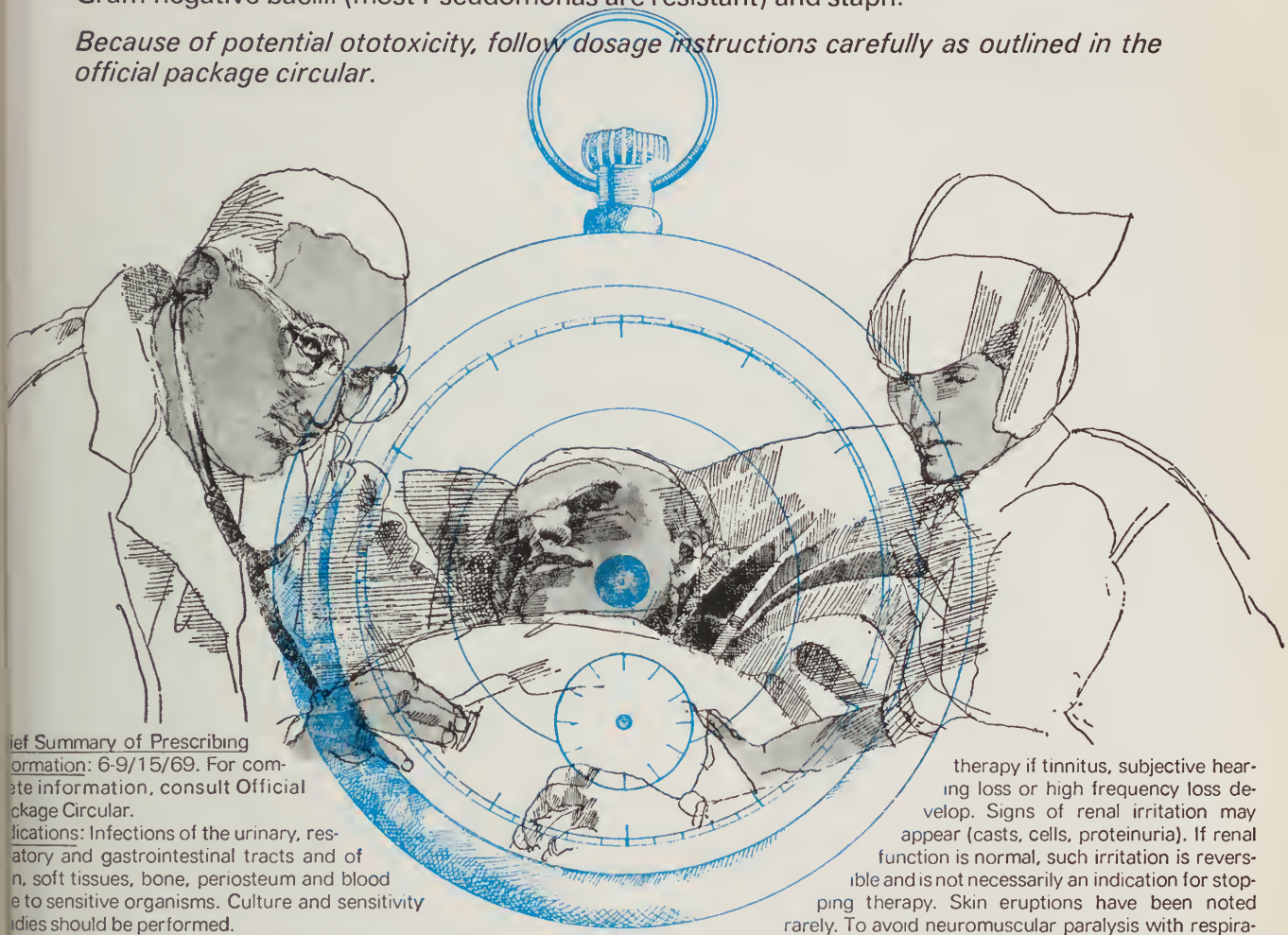
Because of potential ototoxicity, follow dosage instructions carefully as outlined in the official package circular.



ief Summary of Prescribing
ormation: 6-9/15/69. For com-
ete information, consult Official
ckage Circular.
lications: Infections of the urinary, res-
atory and gastrointestinal tracts and of
n, soft tissues, bone, periosteum and blood
e to sensitive organisms. Culture and sensitivity
udies should be performed.
ntraindications: A history of hypersensitivity to the drug.
or auditory damage by kanamycin or other agents may be a contrain-
ation if effective alternative therapy is available.
rnings: Since the drug is excreted almost entirely by glomerular
ration, renal malfunction can cause abnormally high serum levels of
namycin which may prove ototoxic. Assess renal function periodi-
ly, both before and during therapy. Renal dysfunction or pre-renal
otemia sharply increase the risk of ototoxicity and permanent deaf-
ss. In such cases decrease the size and frequency of doses. Discontinue
namycin and check hearing if azotemia increases. In older patients
d patients receiving a total dose in excess of 15 Grams, watch care-
ly for signs of ototoxicity.
ecautions: If mycotic or bacterial superinfection occurs, discontinue
namycin and initiate appropriate therapy. Cumulative ototoxic effects
y be produced by concurrent or consecutive use of other ototoxic
ugs. High doses may cause irritation at injection sites. The drug *should*
t be physically mixed with other antimicrobials.
verse Reactions: Severe irreversible hearing loss may occur. Stop therapy if tinnitus, subjective hearing loss or high frequency loss develop. Signs of renal irritation may appear (casts, cells, proteinuria). If renal function is normal, such irritation is reversible and is not necessarily an indication for stopping therapy. Skin eruptions have been noted rarely. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in postoperative patients until recovery from anesthesia and muscle relaxants is complete.

Dosage and Administration: The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gram daily and should not exceed 1.5 Gram even in the heaviest patients. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours.

Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations: 0.5 Gm. in 2 ml. 1.0 Gm. in 3 ml.

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KANTREX® INJECTION
(kanamycin sulfate)

anxiety: the tyrant

Excessive anxiety can often dominate the patient made vulnerable by illness, surgery, prolonged emotional stress. It can induce or aggravate symptoms, disrupt medical management, divert energy the patient needs for recovery.
The antianxiety action of Librium® (chlordiazepoxide HCl)—used adjunctively or alone—has demonstrated clinical usefulness in virtually every field of medical practice where anxiety complicates the patient's condition.

for the patient ruled by anxiety

Librium® (chlordiazepoxide HCl) 5-mg, 10-mg, 25-mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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PENNSYLVANIA MEDICINE

FEBRUARY, 1971

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Medical Management of The Alcoholic Patient

Menrium® treats the menopausal symptoms that bother him most.

His wife has a lot of different menopausal symptoms, but only a few really irritate *him*. Her hot flashes, her vertigo, her palpitations—that's *her* problem. What really bothers him is her nervousness, her irritability and her excessive anxiety, often expressed by endless "book-shuffling, chain-smoking, reading-lamp" insomnia!

Menrium takes care of hot flashes, vertigo, palpitations in most menopausal women. Menrium provides the well-known antianxiety action of chlordiazepoxide (Librium®) and water-soluble esterified estrogens. It therefore relieves more symptoms than either component separately. It takes care of the vasomotor symptoms as well as the emotional symptoms. This means the symptoms that bother his wife most. And the symptoms that irritate him most.

So, to help them both get through *her* menopause, remember Menrium.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide	5-2	0.2 mg water-soluble esterified estrogens
5 mg chlordiazepoxide	5-4	0.4 mg water-soluble esterified estrogens
10 mg chlordiazepoxide	10-4	0.4 mg water-soluble esterified estrogens

PENNSYLVANIA MEDICINE

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Journal of the Pennsylvania Medical Society

FEBRUARY, 1971 VOLUME 74, NUMBER 2

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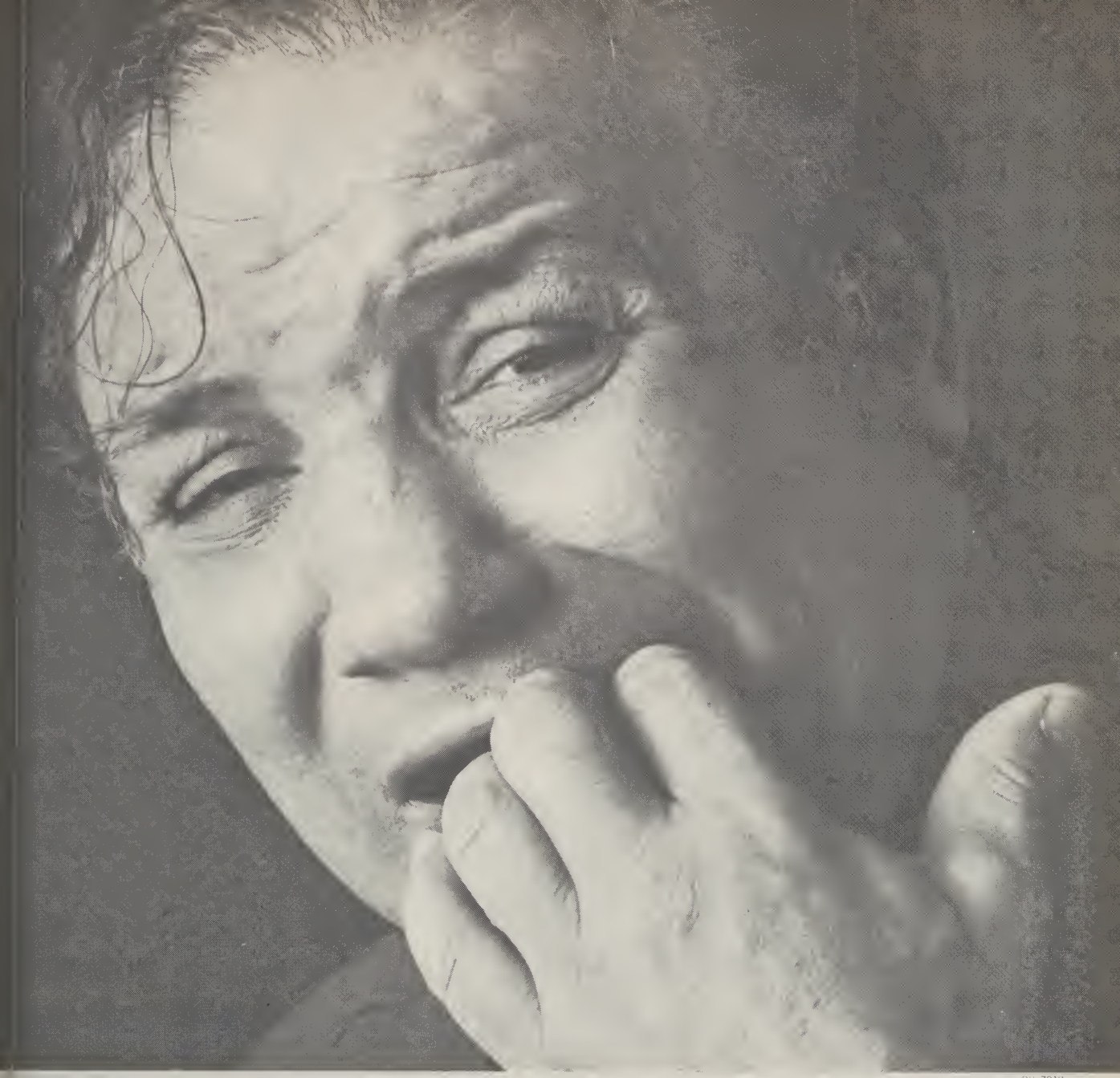

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an economical prednisone that's made a name for itself

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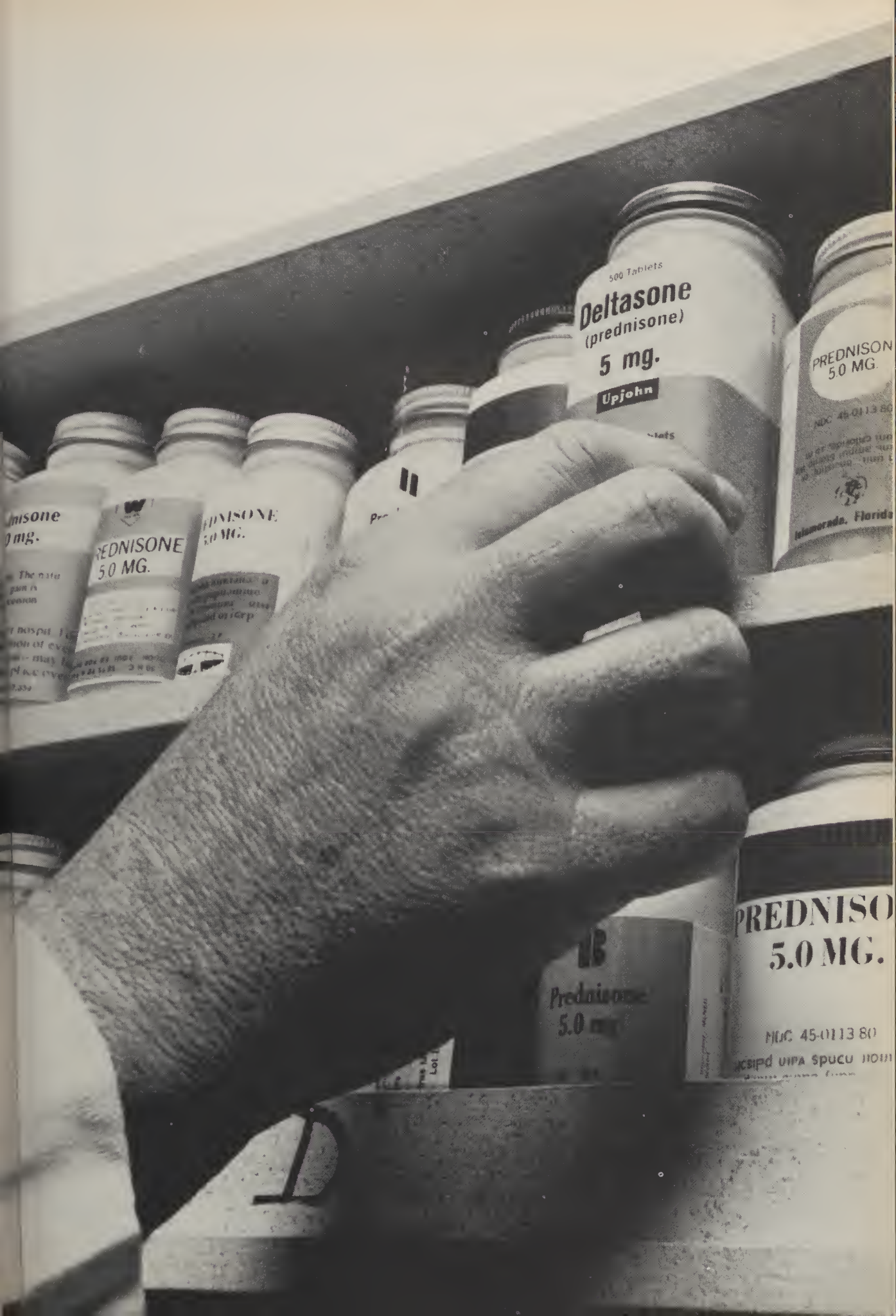
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Prednisone
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(prednisone, Upjohn)

The potency of prednisone exceeds cortisone in glucocorticoid and anti-inflammatory activity by about five times on a weight basis, but is considerably less active than cortisone in mineralocorticoid activity.

Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. *Important:* Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptomatically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9-alpha-fluro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoid during pregnancy, since spontaneous remission of some disease such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis an ulcer regimen and antacid are highly recommended. Take X-ray in peptic ulcer patients complaining of gastric distress, and whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angiitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

Supplied: 2.5 mg., scored—bottles of 100 tablets. 5 mg., scored bottles of 100 and 500 tablets and cartons of 100 tablets in foil strips.

For additional product information, consult the package insert or see your Upjohn representative.

MED B-1S (KQ

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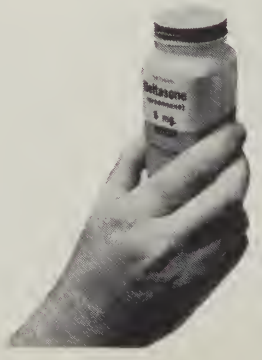

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Before prescribing, please consult complete product information, a summary of which follows:

INDICATION: Relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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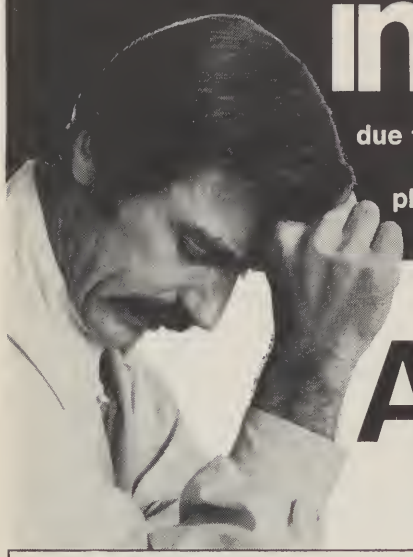
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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Each orange tablet contains:
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Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
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Each white tablet contains:
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Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
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Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
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Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

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Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Monteseno, P., and Evangeliste, I. Methyltesfosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. **2. Dublin, M. F.** Treatment of impotence with methyltestosterone thyroid compound. West Med 5:67, 1964. **3. Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. **4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. **5. Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. **6. Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. **7. Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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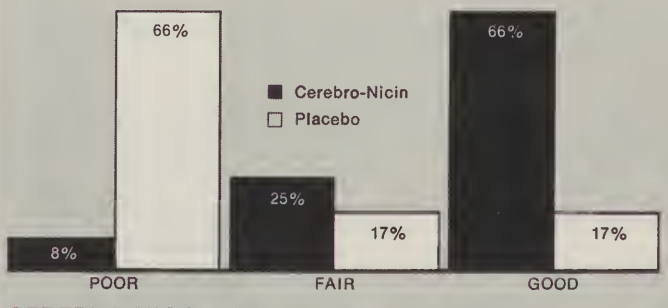

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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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PMS READY WITH TV SPECIAL Finishing touches are being put on an hour-long documentary on health care problems in Pennsylvania, and it is expected to be ready for its TV debut sometime this month. Negotiations are under way with TV stations in all of the state's major viewing areas for public service broadcasting time. The program is an honest appraisal of the major problems and makes the point that any real solution depends on the production of more physicians, which requires more tax support for medical education. Details of the program will be relayed to county medical societies as soon as they become available. The show was produced and is being scheduled for viewing by the Council on Public Service.

GUARD CHANGES IN HARRISBURG Despite the changing of the guard with the inauguration of Milton J. Shapp as governor, Ellsworth R. Browneller, M.D., secretary of health, was asked to continue in his post "until a replacement can be named," but the length of time was not determined...In a major appointment of interest to physicians, the governor named Mrs. Helene Wohlgemuth of Beaver County, formerly part-time welfare consultant to the Democratic House Caucus, as secretary of the Department of Public Welfare, succeeding Stanley A. Miller...Carmela F. de Rivas, M.D., member of the PMS Commission on Mental Health/Mental Retardation, has been appointed to the medical assistance advisory council of the Department of Public Welfare...The PMS Board of Trustees has reiterated its continuing support of the placement of all health matters now in the Department of Public Welfare in the Department of Health...PMS officials are arranging for a meeting with Department of Public Welfare representatives as soon as the post-inaugural dust settles.

FDA HUNTS ACCORD State Society complaints to the Food and Drug Administration about the public fears generated by the manner in which the FDA makes its drug efficacy and withdrawal announcements has resulted in a PMS-FDA meeting and an FDA promise of more cooperation with the profession "in the public interest."

DRAFTERS FOR THE DOCTOR Resumption of the doctor draft is threatened by Washington as the armed forces complain of medical shortages. There has been no draft of physicians since 1969... However consideration is being given to proposals to have the Public Health Service place physicians in both ghetto and rural areas which lack doctors. "Need areas" in the Commonwealth have been surveyed at federal request.

DOCTORS APPEAL ABORTION RULING Two Pittsburgh doctors have appealed an Allegheny County Court of Common Pleas ruling that an unborn child has no rights under the Fourteenth

Amendment of the U.S. Constitution unless the child is subsequently born alive...Drs. John H. McCarthy and Richard N. McGarvey of Magee-Woman's Hospital have asked the state Supreme Court to decide if an unborn child has the right to live.

PMS BOARD SUPPORTS GREAT LAKES CLEAN-UP The Board of Trustees has adopted a series of recommendations from the Council on Education and Science regarding environmental control of the Great Lakes watershed. The Commission on Environmental Health proposed the recommendations which resulted from a meeting of representatives of medical societies from seven states and two Canadian provinces. One of the proposals calls for the formation of an international body with regulatory powers throughout the Great Lakes drainage basin.

PMS SUPPORTS AVAILABILITY OF BLOOD TRANSFUSIONS The PMS Board of Trustees has acted to support efforts to assure the availability of blood transfusions when needed. This has been threatened by a Common Pleas Court of Philadelphia ruling establishing liability for giving a transfusion in the event of any ill effects. The case which is being appealed involves the alleged contraction of serum hepatitis following transfusion. The State Society will assist those involved in the appeal in order to assure that blood will be given when needed by patients.

POCKETBOOK ACTIONS TAKEN Blue Shield is being urged by the State Society to review "inadequacies and inconsistencies" in the Plan B fee schedule and to report back with its findings. The State Society has hit Blue Cross and Blue Shield advertising that implies that the fee schedule programs for over-income subscribers pay all of a physician's charges...Blue Shield has been asked by the State Society to promote the prevailing fee program in lieu of Plan B. The decrease in subscribers under Plan A and its eventual phasing out is under way...Medicare fees, in effect frozen at the 83rd percentile of 1968 fees, are to be changed to the 1969 base but the percentile is to be lowered to the 75th. The expected net result is that one action will cancel out the other and that doctors will be receiving the same dollar amounts as now. The AMA is protesting the action.

MEDICAL CARE FOUNDATION DRAFT TO BE DISCUSSED The PMS Board "received as information draft articles of incorporation and bylaws for the proposed Medical Care Foundation...A discussion of the proposed closed-panel foundation is on the agenda for the PMS Officers' Conference to be held April 28 and 29 at the Penn Harris Motor Inn, Camp Hill...Continuing education requirements for PMS membership and various health care plans are on the agenda also.

PaMPAC Board Members Elected

The PMS Board of Trustees and Councilors at its January 6 meeting elected the PaMPAC Board of Directors, made up of one representative from each of the twelve councilor districts.

PaMPAC board members are:

Paul S. Friedman, M.D., First Council District; R. William Alexander, M.D., Second Councilor District; Richard L. Huber, M.D., Third Councilor District; Benjamin Schneider, M.D., Fourth Councilor District; R. Edward Stone, M.D., Fifth Councilor District; William B. West, M.D., Sixth Council District; Robert F. Beckley, M.D., Seventh Councilor District; William D. Laberton, M.D., Eighth Councilor District; Ralph M. Weaver, M.D., Ninth District; Robert J. Carroll, M.D., Tenth Councilor District; John B. Lovette, M.D., Eleventh Councilor District; and Stanley M. Stapinski, M.D., Twelfth Councilor District.

Taching Methods Subject of Meeting

A two-day conference sponsored by the Pennsylvania Medical Society for hospital-based educators is to be held at the Hotel Hershey, Hershey on March 19 through March 21. The program is designed to promote understanding of educational techniques, theory and hospital involvement in preparing quality educational programs.

The conference will aim at building interest in continued education and construction of new programs to meet the present need of physicians. The conference will also be directed toward discovering areas in need of educational programs.

The registration fee for the conference is $65.00 payable to the Council on Education and Science of the Pennsylvania Medical Society, 20 Erford Rd. Lemoyne 17043. Registration includes a prerequisite reading book, "Preparing Instructional Objectives," all materials at the conference and a ticket to the Hershey Bears vs. Cleveland Barons hockey game.

Phone 301-496-7171 For Drug Abuse Facts

A twenty-four hour telephone answering service to handle requests for information about drug abuse has been established by the National Institute of Mental Health (NIMH). The number to call for information is (301) 496-7171.

Bertram S. Brown, M.D., director of the NIMH, has referred to the service as an information clearinghouse which provides a selection of publications, referrals services and computerized storage and retrieval of data on drug abuse programs.

The publications on drug abuse have been prepared by government agencies and are currently available upon request.

Inquiries in any area of drug abuse should be sent to the National Clearinghouse for Drug Abuse, Box 1701, Washington, D.C. 20013. Requests for literature should be sent to "Publications" at the above address.

Secretary of Health, Education, and Welfare Elliot L. Richardson has announced the appointment of Dr. Bertram S. Brown as special assistant to the secretary for drug abuse prevention in addition to his responsibilities as director of the National Institute of Mental Health.

Dr. Brown will advise the secretary on treatment and rehabilitation services for drug abusers and addicts, and on information and education directives for the prevention of drug abuse and narcotic addiction. He will also assist in the coordination of Federal efforts to inform, educate, treat, and rehabilitate potential and real abusers of all drugs, including narcotics, amphetamines, barbiturates, marijuana, alcohol and others.

DAVID A. SMITH, M.D., New Cumberland, was appointed medical editor of PENNSYLVANIA MEDICINE by the PMS Board of Trustees and Councilors at its meeting January 6. Dr. Smith served as associate medical editor under the late Carl B. Lechner for over two years prior to his appointment. He is director of internal medicine and acting medical director of Harrisburg Polyclinic Hospital and a graduate of Hahnemann Medical College, Philadelphia.

Dr. Brady President In Allegheny County

AMA President Walter C. Bornemeier, M.D., delivered the keynote address January 16 at the 106th Annual Dinner of the Allegheny County Medical Society, which featured the installation of Fred C. Brady, M.D., as president of the county society.

Rupert H. Friday, M.D., program chairman, was master of ceremonies for the affair, which included entertainment.

Dr. Bornemeier, who was installed last June as the AMA's 125th president, is senior attending surgeon at Illinois Masonic Medical Center and, for twenty years, served as instructor in surgery at Northwestern University Medical School.

WILLIAM B. WEST, M.D., Huntingdon has been elected to a one-year term as a board member of the American Medical Political Action Committee based in Chicago. Dr. West is chairman of the Pennsylvania Medical Political Action Committee and a former president of the PMS.

Health Check Planned Under Medicaid Law

John D. Twiname, administrator of HEW's Social and Rehabilitation Service, announced recently that individuals under twenty-one eligible for aid under the Federal-State Medicaid program will be screened and treated for health defects under rules outlined in the *Federal Register*.

If existing health care resources are unable to provide adequate services to all eligible persons under twenty-one, state programs may begin with children under six and extend services to others in specified stages so that all are covered by July 1, 1973. It is estimated that over six million people will be eligible for the medicaid services when the proposed regulations become effective.

Bucks County Society Receives Award For Drug Abuse Program

The Bucks County Medical Society was among the groups awarded certificates of appreciation by the Bucks County Bar Association. The award was presented to the society in recognition of their aid in organizing and maintaining its drug abuse program.

Among the other organizations honored at the ceremonies were the drug control division of the Pennsylvania Department of Health in New Hope, West Chester's Gaudenzia House executive director, John Ruococo, and the special services division of the Bucks county school system.

Drug abuse assemblies held on Law Day, 1970, have led to the continuation of a series of drug abuse programs sponsored by the bar association's drug coordinating committee. A series of drug abuse assemblies has already begun in the schools this year.

Hershey Dean Reveals Faculty Appointments

George T. Harrell, M.D., dean and director of the Milton S. Hershey Medical Center, announced 103 clinical appointments to the center's faculty. Such clinical appointments are made in appreciation and recognition of the Pennsylvania physicians in private practice who have offered to teach medical students.

Although the appointments are renewable annually by the various department chairmen, the titles do not carry salary, fringe benefits or admitting privileges.

Most of the teaching responsibilities previously conducted at Harrisburg Hospital are now carried out at the medical center's hospital. The center plans to continue its affiliation with Harrisburg Hospital which will enable medical students to take a portion of required and elective clerkships at Harrisburg.

Dial Access Has Expanded Services

An increasing number of physicians are taking advantage of the Dial Access service of the Central New York and Susquehanna Valley Regional Medical Programs conducted by the Robert Packer Hospital in Sayre.

Dail Access has expanded its offerings of five minute mini-lectures to 120. The audiotapes cover a variety of diseases, conditions and procedures. Pennsylvania physicians in the 717 and 215 area codes may dial (800) 432-8081 toll-free at any time. Physicians outside of these area codes may take advantage of the service at the regular toll charge.

A complete listing by subject area of tapes now available may be obtained through the Communications Coordinator, SVRMP, Box 541, Camp Hill 17011.

MCP Reveals Withdrawal Of New President-Elect

Mrs. Paul R. Kaiser, chairman of the Board of Corporators of The Medical College of Pennsylvania, has announced that Irving H. Leopold M.D., has withdrawn as president-elect of the College. This decision was reached by mutual consent of the College and Dr. Leopold.

Mrs. Kaiser is immediately reinstating the search committee of the board, which will continue under the chairmanship of Mrs. John T. Brugger. This committee includes representatives of the College's Board of Corporators, administration, faculty, alumnae, students and acting president Marion Fay, Ph.D. Ex officio members of the committee are Mr. Richard B. Herman, chairman of the exeuctive committee of the Board, Dean Bernard Sigel, M.D., and Mrs. Kaiser.

'Hospital Library' Meetings Scheduled

"The Hospital Library," a half-day program designed for chief executive officers of hospitals, hospital-based educators, directors of nursing education and in-service educators, has been scheduled for April 14 at Hershey and April 15 at Pittsburgh. Co-sponsored by the Pennsylvania Medical Society, the conference will explain the role of the library in medical and health sciences education.

Advanced registration is requested. The $5.00 registration fee may be made payable to the Pennsylvania Medical Society.

Drug Abuse, Training Program Get Priority

Former State Secretary of Public Welfare Stanley A. Miller prior to his resignation directed Eastern Pennsylvania Psychiatric Institute, Philadelphia, the department's primary mental health research and training center, to redeploy personnel and facilities to develop a top priority drug abuse and research training program.

Emphasizing the urgency of developing the program, he directed W. A. Phillips, M.D., medical director of the institute, to redeploy a significant portion of its resources, including inpatient care, to develop a clinical program of research and training that will provide leadership in coping with the drug abuse problem on a state-wide scale.

Mr. Miller said, "The problem of drug abuse, especially among the young, is probably one of the major mental health problems of our time.

"Large numbers of our youth in their disenchantment and disillusionment with our society today, turn to drugs as a means of finding meaning and significance in their lives. More often than not, the result is a worsening of the emotional distress rather than an alleviation of it. The frequency with which so many of our young people suffer serious emotional breakdown through drug abuse is a matter of utmost concern.

"It is clear that the mental health program of the Commonwealth has responsibility for providing a major effort in this area. It is imperative that we move immediately and commit a significant portion of our resources to finding ways to cope with this serious situation," he said.

Joseph Adlestein, M.D., formerly deputy secretary for mental health and mental retardation, and now acting secretary of the department, met with administrators and representatives of the Philadelphia, Chester, Bucks, Montgomery, and Delaware county mental health and mental retardation programs, and others concerned with drug abuse, January 5, at E.P.P.I.

The group discussed development of regional plan and determined how state resources can best be utilized in cooperation with voluntary and county programs in developing a collaborative approach to the problems.

The Department of Public Welfare, through its Office of Mental Health, supports several drug abuse programs throughout the Commonwealth at present. All of the county mental health/mental retardation programs have the responsibility for developing programs in this area.

Mr. Miller, who resigned as secretary of the Department of Public Welfare to accept an appointment from former Governor Raymond P. Shafer as chairman of the State Securities Commission, said he plans to remain active as a volunteer in a private capacity in the welfare field.

PMS Council, Blue Shield Resolve Payment Issue

The PMS Council on Medical Service and Pennsylvania Blue Shield have reached agreement on a statement clarifying the distinction between the service benefit concept and an indemnity insurance program. The statement is as follows:

"Under the service benefit concept there is a three-way agreement between the doctor, who is a participating doctor with Pennsylvania Blue Shield, the subscriber, and Pennsylvania Blue Shield.

"Under the Plan A and Plan B agreements, a subscriber who is within the income limit set forth in the agreement is assured in advance that he will not have to pay any additional amount for covered services over the amount allowed by Blue Shield, when treated by a participating doctor.

"Under the prevailing fee program, the concept is the same; however, there are no income limits. The reason for this is that the services provided by a doctor are evaluated by Pennsylvania Blue Shield according to the criteria of usual, customary and reasonable rather than determined by a fixed fee schedule.

"Under an indemnity concept, services are paid for at fixed amounts which are stipulated in the contract. The contract is only between a policy holder and the insurer. The doctor who provides the service has no obligation in this arrangement and is free to bill and collect for the services rendered. Pennsylvania Blue Shield does not offer any indemnity programs. However, subscribers holding Plan A or Plan B agreements who have incomes in excess of the stated limits, in effect have indemnity agreements."

Dr. Roth Elected To Pension Plan Board

Russell B. Roth, M.D., of Erie, speaker of the house of delegates of the American Medical Association, has been elected to the advisory board of directors of the National Foundation of Health, Welfare and Pension Plans.

The sixteen-year old foundation, based in Milwaukee, Wis., is dedicated

DR. ROTH

solely to the education of trustees and others serving on employee benefit plans. Such plans are established under the Taft-Hartley Act, which made employee benefits part of collective bargaining and enabled tax-free employer contributions to benefit trust funds operated by joint trustee boards on which management and labor are equally represented.

Health Insurance Assn. Announces Medical Plan

G. Frank Pruvis, Jr., chairman of the Health Insurance Association of America, recently made a proposal, one of many made in the past year, for a national program designed to stabilize medical costs, improve health care and make comprehensive health insurance available to everyone.

The Health Insurance Association of America is composed of over 300 member insurance firms, which account for 80 per cent of the health insurance written by insurance companies in the U. S.

The proposal draws upon the government, the flexibility and managerial capabilities of private insurers, the scientific skills of health care professionals and consumers. It is believed that if the proposed reforms and additions are made all citizens, regardless of income, will have access to quality health care at a price the nation can afford.

Mr. Pruvis explained that under the proposed program there would be an increase in the supply of health manpower, a promotion of ambulatory health care and benefits for preventative treatment and a strengthening of health care planning on both state and local levels. The program will also make way for improvements in the controls of cost and quality of health care and for the development of national health care objectives.

The health insurance business believes that the delivery of a quality health care is dependent on a broadly-based financing system. Mr. Pruvis noted that such a system could be achieved easily by building on the present foundation of existing voluntary health insurance plans.

In addition to calling for federal standards for health care benefits and for the utilization of the existing insurance structure, the industry's program proposes federal income tax incentives to help assure that benefits are maintained on federal levels. The use of federal and state funds to subsidize the standard benefits to the poor and near-poor is also called for in the program. The near-poor groups would be required to pay premiums scaled to their incomes.

The program would be able to become fully effective by 1973. Initially, however, more extensive state programs for the poor and near-poor would exist rather than for the private group and individual plans.

The association urges increased support for comprehensive health planning agencies and for the creation of a council of health policy advisors on the cabinet level to serve the president by setting up national policy to improve the organization, delivery, quality and financing of health care.

Temple Hosts Fifth Annual College Health Conference

The Pennsylvania Medical Society is one of the sponsors of the Fifth Pennsylvania College Health Conference to be held at Temple University, Philadelphia, March 12 and 13. How students affect and are affected by the present college health programs, as well as other physical and social aspects of the campus environment, will be the general theme of the conference.

Workshops dealing with environmental health problems including noise, waste, crowding, heating, lighting and eating facilities; the advisory function of the school administration in terms of policies and activities directly affecting on-campus health; and campus health education through campus news media and classroom involvement are to be included in the programs. One other workshop will concentrate on the clinical functions which students, administrators and faculty should expect from the college health services.

Wills to Present Glaucoma Course

The Glaucoma Service of the Wills Eye Hospital, affiliated with Temple University Health Sciences Center in Philadelphia, Pennsylvania, is offering a three day course, "The Management of Patients with Glaucoma," on April 7, 8, and 9, 1971. The following lecturers will participate: Mansour F. Armaly, M.D., William R. Green, M.D., P. Robb McDonald, M.D., Kenneth T. Richardson, M.D., and George L. Spaeth, M.D.

The tuition fee is $150, payable to the Glaucoma Service of the Wills Eye Hospital. The course, which will include lectures, practical demonstrations, and discussions of specific cases, is limited to thirty members. Applications will be accepted in the order in which they are received. Inquiries regarding the course should be addressed to George L. Spaeth, M.D., Director, Glaucoma Service, Wills Eye Hospital, Philadelphia, Pennsylvania 19130.

Ambulatory Care Survey Planned

A National Ambulatory Medical Care Survey (NAMCS) is currently being planned by the National Center for Health Statistics in the Department of Health, Education and Welfare.

The survey is expected to provide objective, quantitative information enumerating the types of ambulatory patients seen by physicians, the nature of the patients' problems and the resources for their care. When the survey is in full operation in 1972 it is estimated that some 3,000 physicians and 240,000 ambulatory patients will provide data each year. All physicians will be replaced by new sample physicians after participating for four quarters.

The largest segment of the American health services system in terms of volume and prevalence is ambulatory services. Information on this is needed for planning and organizing health services, for planning efficient utilization of health facilities and manpower, and for determining modifications in medical education.

Topic is Physician's Assistant

SVRMP Sponsors Workshop

"The Physician's Assistant" will be e subject of a day-long Regional orkshop at the Milton S. Hershey edical Center, Hershey, on March 3, onsored by the Susquehanna Valley egional Medical Program.

Developed cooperatively by /RMP's Council on Education and anpower and the medical center, the orkshop will bring to central Penn-lvania some of the pioneers of ysician's assistant training programs ross the nation.

Featured speakers representing spe-ic programs include: D. Robert oward, M.D., Physician's Assistant aining Program, Duke University; rald Bassett, M.D., MEDEX Pro-m, University of North Dakota; d Mrs. Ann Smith, Pediatric Nurse-ractitioner Program, University of olorado. Willard Gamon, M.D., of eney, Washington, will speak from t viewpoint of a preceptor and as e who presently employs a "edex"—physician assistant.

n addition to a discussion of the vious training approaches, Nathan rshey, L.L.B., Professor of Health w, University of Pittsburgh, will d cribe methods of resolving the legal p blems regarding use of physician's a stants.

arry Borland, Ph.D., Assistant P fessor, Department of Behavioral Sence, at Hershey Medical Center a consultant to SVRMP, will report o SVRMP's recent study of physician m power resources. Lawrence Flan-n, of the Altoona Hospital, will di uss his hospital's use of former mil-ta corpsmen in a variety of hospital ro s; and Mrs. Evan L. Porter, of the H pital Education and Research F ndation of Pennsylvania (HERF) w discuss the national MEDIHC pr ram which helps to place former m tary medics into the civilian health ca system.

panel comprised of physician rep-re tatives, an attorney, a health pl ner, labor and industrial leaders, an a legislative representative will di uss the issue.

Reed Babcock, M.D., of Belle-fo e, immediate past chairman of the SV MP's Regional Advisory Group, will serve as general chairman for the workshop, which is open to all interested physicians, health professionals, and other concerned individuals. Registration begins at 8:30 a.m. There will be a $5.00 fee to cover lunch and seminar expenses.

Interested persons should notify Franklin E. Williams, Educational Activities Coordinator, SVRMP, Box 541, Camp Hill, Pa. 17011, before March 1.

Radiological Certification Board Proposed By Federal Agency

Model legislation to aid states in establishing minimal educational and training standards for persons using ionizing radiation in the healing arts has been prepared by the HEW's Bureau of Radiological Health.

Under the model law, state certification of competence would have to be obtained by all people using ionizing radiation in diagnosis and treatment. This would mean that physicians, dentists, medical and dental assistants, and other licensed practitioners would require certification.

The bureau has identified medical and dental diagnosis as the greatest single source of man-made radiation reaching the people of the United States. The model law is designed so that it promotes a reduction in population exposure to radiation by improving the qualifications of persons using the equipment and materials for applying ionizing radiation.

Provisions for both medical and dental radiographic technology boards of examiners to determine the prescribed level of competence for ionizing radiation users have been included in the model law. At this time California is the only state requiring certification of all persons using x-rays on patients.

Copies of the draft legislation, "Model Legislation for Users of Ionizing Radiation in the Healing Arts," prepared by the Bureau of Radiological Health are available from the bureau's Office of Information, 12720 Twinbrook Parkway, Rockville, Md. 20852.

Stoma Clinic Established at MCP

Donald R. Cooper, M.D., chairman of the department of surgery at The Medical College of Pennsylvania, announces that a stoma clinic for the care of patients in the Delaware Valley has been established at MCP, directed by A. Richard Kendall, M.D., and Lester Karafin, M.D., under the supervision of the Department of Urology.

This facility, the first in the Delaware Valley (there is one other such clinic in Harrisburg), services patients with postoperative stomal problems (colostomy, ileostomy, urethrostomy, etc.) and is staffed by a qualified enterostomal therapist, Mrs. Stella Krouse.

Mrs. Krouse, who trained at Cleveland Clinic Hospital, is capable of fitting and caring for stomal appliances. She is experienced in dealing with an individual's problems of adjustment to life with a stoma, including consulting on diet, skin problems and irrigating techniques.

The clinic is designed to help in adjustment to life with a stoma and does not deal with a disease process. This has already been accomplished by surgery. While medical backup is provided, all medical and surgical problems will be cared for by the patient's referring physician.

Physicians can schedule appointments for their patients by calling The Medical College of Pennsylvania, VI9-0400, Extension 4480 and requesting the Stoma Clinic. Or individuals may call for their own appointments. Further information can be obtained by contacting the Department of Urology at The Medical College of Pennsylvania.

State Certified Nursing Homes Now Number 578

A total of 578 nursing homes with accommodations for 40,138 patients were certified or licensed to operate in the Commonwealth as of December 15, 1970, according to Dr. Alfred C. Kraft, commissioner of medical services and facilities for the Pennsylvania Department of Public Welfare.

The licenses, issued by the Nursing Home Division, were granted to 390 proprietary and 188 nonprofit institutions, showing a decline of 27 below the 605 nursing homes approved last year.

Dr. Kraft pointed out that the department has the responsibility for the development, maintenance and improvement of standards of patient care in all general and special hospitals, nursing homes, extended care facilities and restoration centers (formerly called geriatric centers).

"The activities of this office," he added, "are designed to assure that all persons who require medical services, either as inpatients or outpatients, receive the highest quality of care."

In addition to the nursing homes, 17 proprietary and 17 nonprofit intermediate care facilities were surveyed and approved by the department. Intermediate care facilities offer minimal nursing care rather than skilled nursing care provided in other type homes.

Fifty-nine county institutions, capable of accommodating 15,939 persons, were certified to provide infirmary and residential care.

DAVID A. SMITH, M.D., (left) recently appointed medical editor of PENNSYLVANIA MEDICINE and 1970 president of the Dauphin County Medical Society congratulates Raymond C. Grandon, M.D., (right), on his installation as 1971 DCMS President. Dr. Grandon is secretary of PMS. Looking on are Drs. G. Winfield Yarnall (second from left), DCMS secretary-treasurer and Robert P. Sutlinger, chairman of PMS Council on Medical Service. The installation ceremony took place in January.

AAP Seeks Change In Marijuana Law

According to the American Academy of Pediatrics (AAP) the penalty for possessing marijuana, which is presently considered to be a felony, should be changed to a misdemeanor.

The AAP Massachusetts chapter prepared a statement emphasizing that marijuana is a non-addicting hallucinogen, rather than a narcotic, and as such should not be treated as a narcotic drug as defined by the Harrison Narcotic Act.

Marijuana is a potentially harmful drug, and according to the academy it should not be legalized at this time.

Experts Discuss Treatment Of Drug Overdose Victims

A panel of experts who deal with the medical, legal, psychological and toxicological aspects of the drug problem discussed "Emergency Room Diagnosis and Treatment of Acute Drug Overdose" Wednesday, January 6, in the Allegheny County Medical Society (ACMS) headquarters building, 713 Ridge Avenue, North Side.

Sponsored by the ACMS Drug Abuse Committee and designed to provide basic medical facts concerning the diagnosis and treatment of known or suspected drug overdose victims, the program included a review of differential diagnosis and recommendation of treatment modalities.

Cyril H. Wecht, M.D., chairman of the Drug Abuse Committee, moderated a panel discussion dealing with narcotics, sedatives, hypnotics, amphetamines, hallucogens, psychiatric problems, the role of the toxicology laboratory, and legal ramifications of emergency treatment of dangerous drugs.

CORRECTION

Dr. Joseph B. Kahn, a podiatrist who recently joined the staff at Geisinger Medical Center as a part-time associate in the department of orthopedics was listed in error in the January, 1971 issue of M.D.'s in the News as a doctor of medicine. Dr. Kahn also has a private practice in Selinsgrove.

Public TV Drug Abuse Programs Broadcast Throughout State

Arnold Palmer and "Brother John"... David Susskind and Big Brother and the Holding Company...O. J. Simpson and the "Bugaloos"...the Surgeon General of the U.S....Fred Rogers and a bunch of ex-junkies.

An unlikely crew? Perhaps so, but this month, they'll all join forces for what is probably the most comprehensive series on drug in the history of broadcasting. It's called "The Turned On Crisis," and the 200 TV stations of the Public Broadcasting Service will air the eight one-hour programs during prime time in February. The series has been designed to examine the hows and whys of drug abuse, and what parents and teenagers can do to provide alternatives to a "drug crisis." Commonwealth newspapers will list times of the shows on public TV stations throughout the state.

A one-hour edited version of psychologist Dr. Carl Rogers' sixteen-hour encounter session on drugs kicks off the series with "Because That's My Way." During the session with ten individuals from various backgrounds in the drug culture, Rogers directs meaningful confrontations between a narcotics agents, a revolutionary, a college student who hasn't yet turned on to drugs, a nurse whose son "overdosed" on heroin, and a seventeen-year-old arrested for narcotics possession.

"The First Dimension: Information and Understanding" serves as the basis for further dialogue on drugs throughout the series. With O. J. Simpson as host, this fast-paced multi-level approach to information and understanding features numerous guest participants, computor animations and film vignettes in the delivery of facts and survey of attitudes toward drug use and abuse. Participating authorities and personalities include U.S. Surgeon General Jesse Steinfeld, Dr. Sidney Cohen, Dr. Helen Nowlis, Arnold Palmer, Denise Nicholas, Frank Gorshin, and Greg Morris.

"Say What We Feel, Not What We Ought To Say" is a series of interrelated vignettes about members of a community attempting to solve their drug problems. The program probes the contrasting attitudes of youth and establishment as actor/participants react to the situational context of proposals for closing a controversial youth center and of policing high school halls for drugs.

Next in the series is "The Shade of a Toothpick," an examination of projects and approaches to drug prevention across the nation. In the program, hosted by David Susskind, focus is on projects undertaken in Berkeley, Pittsburgh, and Stamford, Connecticut; Public Television's Fred Rogers makes an appeal to parents to respond creatively to the needs of their children, and David Susskind moderates a panel discussion with law enforcement authorities on the role of organized crime in the drug crisis.

"To Keep It, You Have To Give It Away" explores the inner sanctum of rehabilitation centers. Interviews and action footage with addicts, doctors, psychologists and other professionals document life at Synanon's new city at Tomales Bay, north of San Francisco, the Clinical Research Center of the National Institute of Mental Health in Lexington, Ky.; Black Action, Inc., a methadone maintenance program in Pittsburgh; the Washingtonian Hospital in Boston and others. The program emphasizes that in view of the many different approaches to rehabilitation, no single approach is necessarily the "right" one, but instead, the different modalities have been developed out of a wide range of different individual needs.

A special television production of "The Concept," the long-run off-Broadway play, illustrates one particular approach to drug rehabilitation. Self-

PHYSICIANS have a responsibility to learn about drug abuse in America. You have an opportunity to see what is happening throughout America. "The Turned On Crisis," is a series of eight programs which examine in dramatic form the drug abuse problem which exists in most American communities today. Check your local public TV station listings for times of the shows scheduled for February. Above is a scene from the program "Because That's My Way" featuring Dr. Carl Rogers, psychologist, in an encounter session with young people.

SCENES FROM "Say What We Feel, Not What We Ought To Say" (above) and "High Is Not Very Far Off The Ground," (below) portray two aspects of drug users' problems in relation to established community standards, and their problems in communication with each other.

realization therapy is dramatized as ex-addicts, all members of New York's Daytop Village, interact with one another in a series of improvisations about themselves and their arduous route back to reality.

The medium is the message in "Why Can't You Hear Through The Noise in Your Ear?" Performance and dialogues with top youth-cult musicians, interpreted by the program's host, demonstrate for the over-30 group that rock music communicates many positive values despite the "loud sound."

"High is Not Very Far Off The Ground" features a heated debate-discussion on marijuana by authorities from the medical and legal professions. The debate is innercut with episodes from a town meeting on drug abuse during which adults and youth, in confrontation over "hard" vs. "soft" drugs, support the notion that marijuana and "soft" drugs are an issue based on morals rather than fact.

WOED (public television in Pittsburgh) broadcast the series last October and distributed pamphlets for the public on topics ranging from methods of prevention and community action to facts on drugs designed for family reading and discussion.

"The Turned On Crisis" is a project on drug abuse of the Pennsylvania Public Television Network. The shows were produced by Public Television Station WQED. The series is a three-pronged effort: eight hours of prime time programs will reach the families in their homes.

Six half-hour shows aimed at educators, including school-board members, teachers, administrators and supervisors will be shown in March and April.

Six twenty-minutes programs will be beamed to junior high school students' in the classroom next fall. Both the educators' and students' programs will be tested, evaluated, and, if necessary, revised in pilot studies before they are nationally aired.

DIANE and Paul, George, Amy, and Tony, are some of the actors in "The Turned on Crisis."

"Most often it's my stomach, but I get headaches too. My muscles hurt and I'm fidgety and sometimes I cry?"

Somatic symptoms and concerns caused by anxiety respond particularly well to Sinequan®
DOXEPIN HCl

(Please see last page for full adverse reactions, contraindications, warnings and precautions.)

"Everything I do is half done. I'm restless, nervous, tired all the time and always nagging."

Anxiety and lack of energy respond particularly well to

Sinequan
DOXEPIN HCl

Marked antianxiety action . . .

The antianxiety effect of Sinequan (doxepin HCl) was compared to that of either diazepam or chlordiazepoxide in ten double-blind studies[1,2] of 422 patients with psychoneurotic anxiety. An analysis of the symptom rating scales revealed that Sinequan was unsurpassed by the two tranquilizers in treating a broad range of anxious symptomatology.

Global evaluation of the double-blind studies also expressed the comparative effectiveness of Sinequan:

SINEQUAN VS. CHLORDIAZEPOXIDE IN 5 DOUBLE-BLIND STUDIES

DRUG ADMINISTERED	SINEQUAN	CHLORDIAZEPOXIDE
TOTAL NO. OF PATIENTS	77	72
NUMBER IMPROVED	**64**	**56**
MARKED	21	7
MODERATE	27	23
SLIGHT	16	26
% IMPROVED	**83%**	**78%**

SINEQUAN VS. DIAZEPAM IN 5 DOUBLE-BLIND STUDIES

DRUG ADMINISTERED	SINEQUAN	DIAZEPAM	PLACEBO
TOTAL NO. OF PATIENTS	118	102	48
NUMBER IMPROVED	**100**	**75**	**33**
MARKED	47	34	12
MODERATE	29	29	11
SLIGHT	24	12	10
% IMPROVED	**85%**	**74%**	**69%**

Overall evaluations[1] of patients treated with Sinequan revealed that:

- 84% of 263 patients with symptoms of anxiety showed marked, moderate, or slight improvement
- 87% of 40 patients with symptoms of anxiety accompanying organic disease showed marked, moderate, or slight improvement
- 83% of 142 patients with symptoms of anxiety and depression showed marked, moderate, or slight improvement.

. . . and significant antidepressant activity

Sinequan®
DOXEPIN HCl

Starting dosage:
25 mg. t.i.d. for mild to moderate anxiety

The tranquilizer that is an antidepressant.
The antidepressant that is a tranquilizer.

"In a double-blind and placebo-controlled study of doxepin and diazepam in therapy for anxiety superimposed on underlying gastrointestinal disease in 60 patients, doxepin appeared comparable to diazepam in reducing anxiety."

Kasich, A. M.: Psychosomatics Supplement 10:18, May-June, 1969.

(Please see last page for full adverse reactions, contraindications, warnings and precautions.)

Analysis of standard symptoms rating scales[1] proved the effectiveness of Sinequan (doxepin HCl) in decreasing the intensity and incidence of the most prevalent psychoneurotic symptoms:

Symptom	Improvement with Sinequan
Anxious Mood	**74%** (59 of 80 patients[a])
Fears	**73%** (48 of 66 patients[a])
Difficulty in decision-making	**63%** (12 of 19 patients[b])
Tension	**79%** (63 of 80 patients[a])
Depressed Mood	**72%** (50 of 69 patients[a])
Loss of interest	**73%** (11 of 15 patients[c])
Social Withdrawal	**62%** (13 of 21 patients[b])
Somatic Symptoms (General)	**76%** (31 of 41 patients[a])
Respiratory Symptoms	**83%** (19 of 23 patients[a])
Gastrointestinal Symptoms	**77%** (54 of 70 patients[a])
Cardiovascular Symptoms	**67%** (14 of 21 patients[a])
Insomnia	**73%** (53 of 73 patients[a])

Rating scales used for symptom evaluation
a. Hamilton Anxiety Scale (Modified)
b. Wittenborn Symptom Rating Scale
c. Anxiety Check List

Effective control of anxiety's most prevalent psychic and somatic symptoms... relief of underlying depression

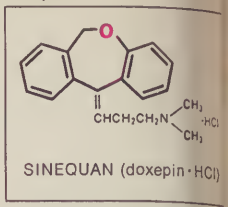
Sinequan®
DOXEPIN HCl

Starting dosage:
25 mg. t.i.d. for mild to moderate anxiety

Sinequan (doxepin·HCl) **Capsules**

Description. Sinequan (doxepin·HCl) is a new dibenzoxepin psychotherapeutic agent with marked antianxiety and significant antidepressant activity.

Chemistry. Sinequan (doxepin·HCl) is a dibenzoxepin derivative and is the first of a new family of psychotherapeutic agents. Specifically, it is an isomeric mixture of N,N-Dimethyl-dibenz(b,e)-oxepin-$\Delta^{11(6H)}$, γ propylamine hydrochloride.



SINEQUAN (doxepin·HCl)

Indications. In a carefully designed series of controlled studies, Sinequan (doxepin·HCl) has been shown to have marked antianxiety and significant antidepressant activity. Sinequan (doxepin·HCl) is recommended for the treatment of:

(1) Patients with psychoneurotic anxiety and/or depressive reactions. (2) Mixed symptoms of anxiety and depression. (3) Alcoholic patients with anxiety and/or depression. (4) Anxiety associated with organic disease. (5) Psychotic depressive disorders including involutional depression and manic-depressive reactions.

The target symptoms of psychoneurosis that respond particularly well to Sinequan (doxepin·HCl) include anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

In those patients in whom anxiety masks the depressive state, Sinequan (doxepin·HCl) is of particular value since it exerts a potent antidepressant effect as well as antianxiety activity.

Patients who have failed to respond to other antianxiety or antidepressant drugs may benefit from treatment with Sinequan (doxepin·HCl).

Clinical experience has shown that Sinequan (doxepin·HCl) is safe and well tolerated even in the elderly patient.

In a large series of patients systematically observed for withdrawal symptoms, none were reported. This is consistent with the virtual absence of euphoria as a side effect and the lack of addiction potential characteristic of this type of chemical compound.

Contraindications. Sinequan (doxepin·HCl) is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan (doxepin·HCl) is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan (doxepin·HCl) has not been studied in the pregnant patient. It should not be used in pregnant women unless, In the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan (doxepin·HCl) in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan (doxepin·HCl). The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of the possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan (doxepin·HCl) has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan (doxepin·HCl), however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan (doxepin·HCl) can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan (doxepin·HCl) does exert a significant blocking effect. In addition, Sinequan (doxepin·HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dosage range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Sinequan (doxepin·HCl) is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., and 50 mg. of doxepin in bottles of 100; and 25 mg. and 50 mg. in bottles of 1000.

References: 1. Data on File, Medical Research Laboratories, Pfizer Pharmaceuticals, Pfizer Inc., Groton, Conn.
2. Pitts, N.E.: Psychosomatics 10:164, May-June, 1969.

Pfizer
LABORATORIES DIVISION
PFIZER INC., NEW YORK, N.Y. 10017

Issued September 1969

When Preventing Constipation is a Concern . . .

Consider

SURFAK®

dioctyl calcium sulfosuccinate

(stool softener)

Surfak prevents constipation:

- **naturally**
  - . . . without bowel distention
  - . . . without adding sodium to the system
  - . . . without requiring unusual intake of water
- **conveniently**—one 240 mg. capsule per day
- **economically**—costs less per effective daily dos

Supplied: Bottles of 15, 100 (FSN 6505-926-8844) and 1000 (FSN 6505-890-1627) and Unit Dose 100's (10 x 10 strips).

*based on actual drug store survey of prescribed dosages

HOECHST
PHARMACEUTICAL CO.
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C-166

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

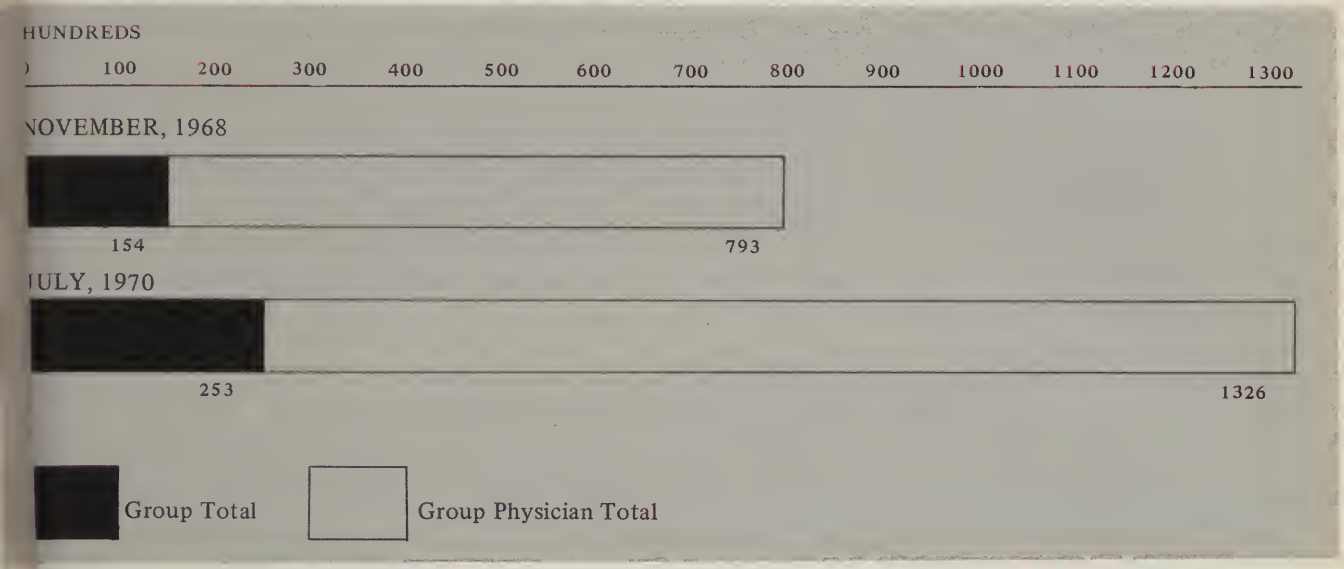
SK&F

SK&F Co., Carolina, P.R. 00630
a subsidiary of Smith Kline & French Laboratories

DZ-108

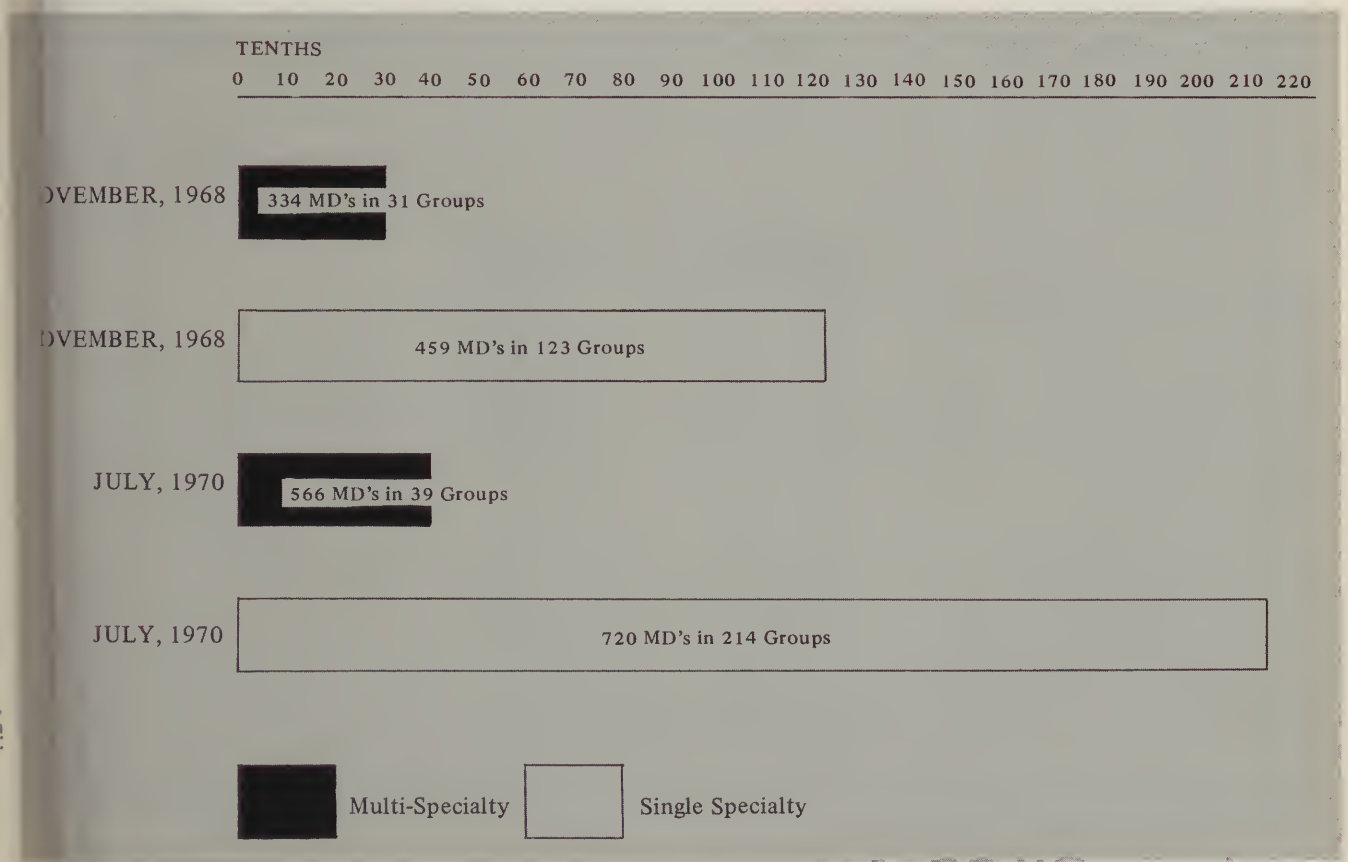
Commonwealth Sees Growth In Group Practice

Growth in Groups, Group Physicians in Pennsylvania



THE RAPID GROWTH of group practice in Pennsylvania, as shown on the graphs above and below, reflects similar growth throughout the nation according to AMA studies. That this growth of groups will continue is almost assured, since polls of medical students indicate that 80 per cent, if given a preference, would choose to practice as part of a group.

Tally of Group Physicians, and Groups by Type



PENNSYLVANIA MEDICINE capitol report

In The Commonwealth

As a new administration begins work on the monumental problems facing the Commonwealth, and as a number of freshmen legislators start learning how it's done in Harrisburg, the words of former Secretary of Welfare Stanley A. Miller, who resigned early in January, may well serve as a guide to all servants of the people of Pennsylvania—veterans and freshmen alike.

The words are taken from a year-end statement from the secretary to the employees of his department and says in part:

"First we must reaffirm our commitment that all of the people of Pennsylvania are served when we serve well those who need care, help and protection.

"There are still people within the state who feel that mental illness only happens to the other man—and yet our developing community mental health/mental retardation programs potentially could benefit all our citizens. That is but one example of the larger universe served by the programs of the department.

"Second we must honestly admit that the Department of Public Welfare faces a serious crisis of confidence in its programs.

"I asked last year that we open wide the doors of the department. To a large extent that has been accomplished during 1970. We have visited many areas of the state, met with countless voluntary groups, given over 100 speeches and toured a majority of the institutions which we operate.

"The third guideline was that we must have the guts to walk a sensible middle course in the loud, cantankerous rhubarb that is raging in America today about welfare and its cost.

"During this past year for the first time, people in need were receiving 100 per cent of the public assistance standard.

"The fourth guideline was in the field of mental health and mental retardation—let us complete the far from finished task of eliminating forever the warehousing of human beings.

"And the last guideline was: we must make more services of the Department of Public Welfare directly valuable to all of the people of Pennsylvania."

In The Nation

Federal Government To Provide Care

The federal government now has the authority to expand the U.S. Public Health Service to provide direct medical and other health care services in ghettos and rural areas where there are shortages of physicians and other health personnel.

Before such a program can be started, the state and local medical societies must certify that it is needed.

The Senate approved the authorizing legislation, 66 to 0, and the House by an almost unanimous voice vote. President Nixon signed it into law on December 31 although the secretary of Health, Education and Welfare, and the PHS surgeon general had asked Congress to defer action until the president presents his overall health program early this year.

The legislation authorized $10 million for the current fiscal year ending next June 30, $20 million for fiscal 1972 and $30 million for fiscal 1973. The money must be appropriated before it is available for the program.

President Vetoes

President Richard M. Nixon's pocket veto of the family practice bill, which would allow Congress to provide funds for medical schools to establish or expand departments of family practice, came with a promise from the president that the administration will be offering early in 1971 a comprehensive package of health legislation—the first such from the administration, although numerous other plans have been offered in the past year to solve the so-called "growing health care crisis."

Meanwhile, certain congressional leaders have indicated they will challenge the constitutionality of the pocket veto as it was used in this instance.

PENNSYLVANIA MEDICINE medical memorabilia

Celestial Bed

In 1779, James Graham, M.D., a London quack, developed a "celestial bed" which assured conception to occupants — young or old. The charge for the services was fifty guineas.

Once in the celestial bed an organ concert was conducted for nearly an hour. This was followed by the approach of a magician to feel the pulse of the faithful, provide them with breakfast, and send them on their way. It was only a few years later that Dr. Graham's Temple of Health failed.

Dr. Graham next developed a fasting cure which would assure life for a century. Unfortunately, Dr. Graham died before he was fifty.

Clean Hands Carry Disease

Oliver Wendell Holmes gained his fame from literary works rather than as a physician. In his *Medical Essays* he urges reform in medical practices. In one passage he wrote about his theory of the transmission of disease by way of the physician's own hand.

A Dr. Meigs of Philadelphia was outraged at such an imputation that a physician's hands were not clean. He quoted numerous cases of infection occurring in the practice of Dr. Simpson of Edinburgh, a great physician and eminent gentleman.

Dr. Holmes defined his position succintly with regard to Dr. Simpson: "Dr. Simpson attended two of Dr. Sidney's cases (puerperal fever), and freely handled the diseased parts. His next four childbed patients were affected with puerperal fever, and it was the first time he had seen it in his practice. As Dr. Simpson is a gentleman, and as a gentleman's hands are clean, it follows that a gentleman with clean hands may carry disease."

m.d.'s in the news

William H. Sewell, M.D., a cardiac ırgeon at the Guthrie Clinic Ltd. in ıyre, received the Smith, Kline and rench Award at the Southern Thoracic ırgical Association's annual meeting. he award, presented to Dr. Sewell / the current president of the asso- ation, Watts R. Webb, M.D., of allas, Texas, is presented to the ıthor of the outstanding scientific ıper presented at the meeting.

Leonard F. Bush, M.D., chief of ıff at Geisinger Medical Center in ınville, announced the appointment Henry L. Hood, M.D., director of ırosurgery, to the position of asso- ıte chief of staff, and Harry C. ımey, M.D., associate in the de- ırtment of psychiatry, to the position associate medical director.

DR. HOOD

DR. STAMEY

Anthony H. Vagnucci, M.D., has b n appointed associate professor of ndicine at the University of Pitts- b gh School of Medicine. He has been a liated with the school since 1965 a with Montefiore Hospital as chief o the adrenal unit. Dr. Vagnucci has p lished extensively in the field of m abolic and endocrine response.

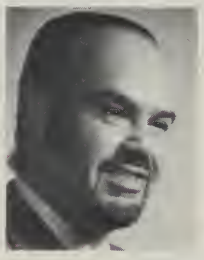
Nancy N. Huang, M.D., chief of the se ion of chest disease at St. Chris- tcher's Hospital for Children in Phila- dohia, delivered a speech on the use o the drugs cephaloridine and cephal- ex in treating children with chronic re iratory disease at a recent inter- nıonal symposium sponsored by Eli Li/ Company in London, England.

oseph R. DiPalma, M.D., dean of H nemann College and Hospital has be selected as one of 1970's "out- st ding educators of America." Dr. Dilma is one of 5,000 of the co try's foremost educators chosen fo their exceptional service, achieve- m ts and leadership in education each ye. As well as his responsibilities as de , he has served the college as a professor and chairman of the depart- ment of pharmacology since 1950.

Edward C. Rosenow, Jr., M.D., the executive director of the American College of Physicians participated in a seminar sponsored by the Montgomery County Mental Health and Rehabilita- tion Board in cooperation with the Penn Foundation for Mental Health, Inc. The topic under discussion at the seminar was psychiatric emergency ser- vice.

Samuel B. Hadden, M.D., Philadel- phia, has been a guest speaker for various groups recently. His lecture tours included speaking for the Penn Foundation for Mental Health, Inc., the New England Obstetrical and Gyn- ecological Society and at a Catholic University Symposium. Dr. Hadden's topics ranged from management of character and behavior disorders to group psychotherapy in the treatment of homosexuality.

George E. Erhlich, M.D., director of rheumatology at the Arthritis Center of Albert Einstein Medical Center (AEMC), stated that arthritic patients can be saved from crippling and dis- ability, and that many patients already crippled by the disease can be salvaged. Dr. Erhlich made the statement at the Thirteenth Annual Reunion Day of the AEMC School of Nursing Alumni Association where he discussed con- temporary trends in the management of arthritis.



DR. ERHLICH

DR. PANDELIDIS

DR. MERRITT

DR. THORSEN

Paul H. Keiser, of York Hospital's Board of Directors, announced the appointment of heads to medical de- partments within the hospital. The doctors named were P. Kirk Pandelidis, M.D., chairman of the department of psychiatry; William B. Thorsen, M.D., chief of the division of gastroenter- ology, and John A. Merritt, Jr., M.D., chief of the division of hematology.

The appointment of Edwin H. Hop- ton, M.D., to assistant professor of medicine at the Milton S. Hershey Medical Center was announced recently.

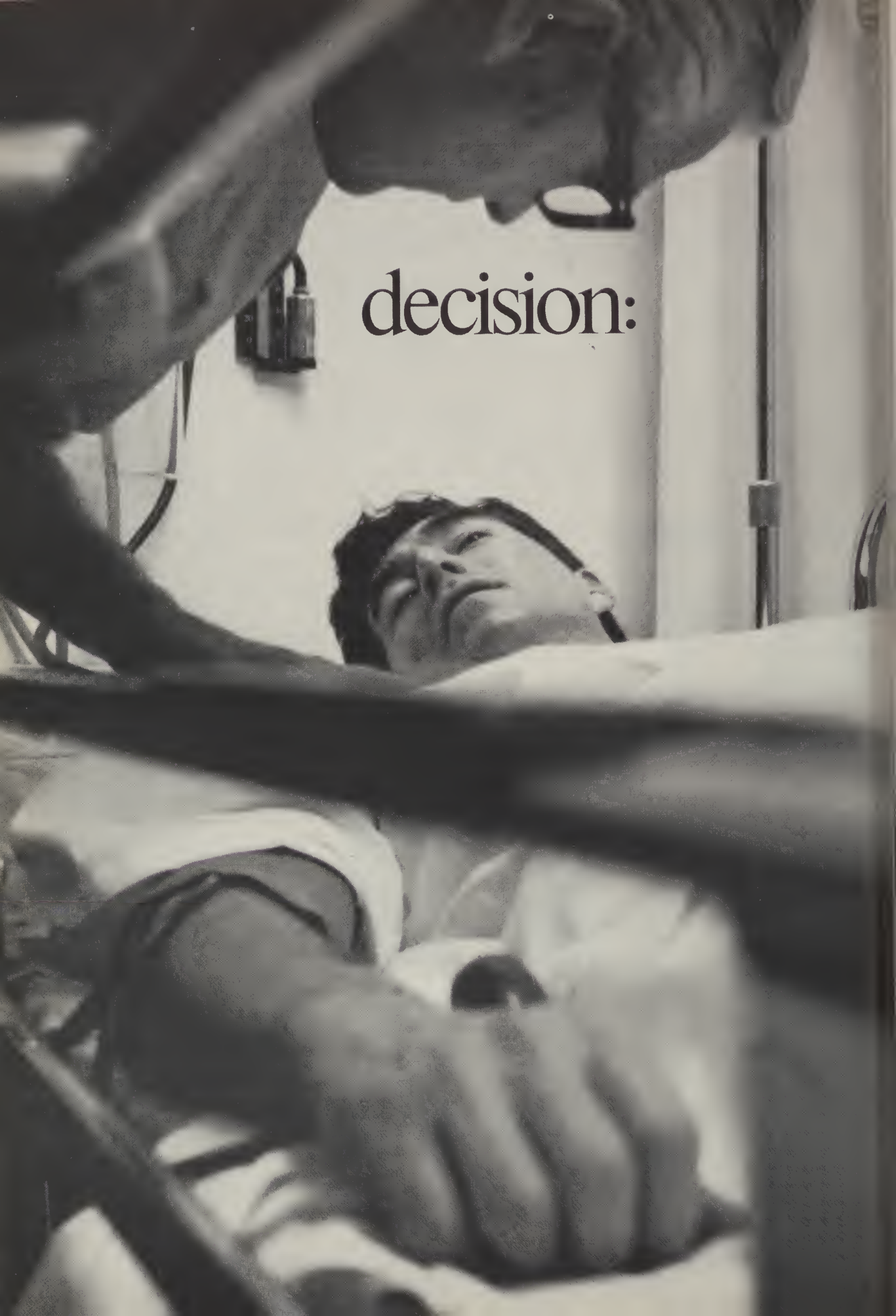
The promotion of Ethel Weinberg, M.D., to associate dean of the Medical College of Pennsylvania was announced by the school's acting president Marian S. Fay. Dr. Weinberg is a graduate of Hahnemann Medical College.

F. S. Cheever, M.D., vice-chancellor for the University of Pittsburgh's School of Medicine's Health Profes- sions, was elected president of the University Health Center of Pittsburgh at a recent election of officers held by the board of trustees. The University Health Center of Pittsburgh is com- posed of Children's Hospital of Pitts- burgh, Eye and Ear Hospital, Magee-Wo- mens Hospital Association of Western Pennsylvania, Presbyterian-University Hospital, Western Psychiatric Institute and Clinic, and the University of Pittsburgh.

The appointment of Michael D. McGuire, M.D., as director of the Norristown State Hospital was an- nounced by state Secretary of Public Welfare Stanley A. Miller. Dr. McGuire succeeds Carmela F. deRivas, M.D., who retired after serving for seven years as head of the institution.

Frank A. Elliott, M.D., director of the department of neurology at the Pennsylvania Hospital in Philadelphia has received a grant for the extension of the hospital's stroke prevention program. The John A. Hartford Foun- dation, Inc., of New York City, pro- vided the funds for the program. Since 1967 the group has provided more than $330,000 for the establishment of a Stroke Prevention Clinic.

Nearly 100 physicians and educators gathered at Geisinger Medical Center recently to hear featured guest speaker Arthur Keeney, M.D., ophthalmologist in chief at Wills Eye Hospital in Philadelphia speak on dyslexia. Thomas E. Cadman, M.D., a pediatric neuro- logist at Geisinger also spoke at the meeting.


decision:

Loridine® I.M.
Cephaloridine

1.5 to 3 Gm. daily successfully treats many moderately severe infections*

- bactericidal action in vitro against susceptible organisms causing:
  pneumonia
  urinary tract infections
  septicemia
  abscesses
- broad-spectrum activity
- relatively painless I.M. injection

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

Lilly

000903

Loridine®
CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Loridine®
CEPHALORIDINE

Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169

Additional information available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly

Is It Wickedness Or Is It A Disease?

Morality that interferes with the objectivity required to equately care for the sick is pseudo-morality and must be nsidered immoral.

In our society there are many sick people whose illness is ological ly related to social, economic and psychological sturbances. In the past and in the here and now, there are gments of our society who consider certain categories of ing human beings as law-breakers—undeserving of the ne concern and attention as that received by those suffer- ig with more conventional and socially acceptable ailments at affect mankind.

For too long the chronic alcoholic has masqueraded as a ssic example of the well person who drank too much for o long until he was sick. In the past, attention has been fused on the complications of the alcoholic but little consideration was given to the concept of alcoholism as a distinct disease entity until relatively recent.

As the trend to accept alcoholism as a disease continues to grow, the need for improvement in earlier detection techniques and earlier institution of treatment becomes obvious. The utilization by the physician of his hospital and community resources to cope with his alcoholic patient is essential.

In this issue, two articles are offered which provide the practicing physician with general and specific information of value in the management of the ambulatory and hospitalized alcoholic patient.

It is the aim of the staff of PENNSYLVANIA MEDICINE to continue to provide to the primary physicians readily usable information in the management of their patients afflicted with addictive diseases.

DAS

Infinite Pains

How-to-do-it articles in medical journals are sometimes frowned upon by the upper classes in the world of medical publishing. That viewpoint is certainly understandable. This kind of essay does not push forward the boundaries of scientific knowledge. On the other hand, an item of improvement in a technique can be discovered by many of us and such a finding ought to be reported.

But there is another kind of report of a technical procedure which deserves your attention — the methods of a master.

In this issue on page 59, we are proud to present an essay of the latter sort. This paper gives great detail of the methods of Dr. Harry E. Bacon in his treatment of cancer of the colon, rectum and anal canal and deserves the study of any doctor who undertakes to treat this common, highly fatal, but often curable disease.

The methods are explicitly and clearly defined in the essay. But this paper has a clear but less obvious message — the necessity of doing *every* big and little thing, no matter how difficult or trying, which can give the patient an advantage. Meticulous is the word for the techniques described .

One need not be a surgeon to derive this message from this paper. We ought all to learn to leave no stone unturned, to take every stitch in time and, in short, to be as careful and diligent as we can be in our practices. The reward in better diagnoses and more successful treatment will be mainly the patient's gain. But the self-satisfaction to the physician is in itself the justification for the extra effort.

CBL

The Value Of The Tumor Clinic

The Wainwright Tumor Clinic Association of Pennsylvania was organized as the Pennsylvania Tumor Clinic Association at a meeting of tumor clinic groups held at Jefferson Medical College in 1930. Jonathan Mayhew Wainwright, M.D., was its first president and remained president until his death in 1941. In 1936, at a meeting held in the surgical amphitheater of the old Lankenau Hospital where John B. Deaver, M.D., performed his surgical miracles, the name was changed to honor the name of its first president.

Dr. Wainwright was a surgeon with a special interest in cancer. He was the first chairman of the Commission on Cancer of the Pennsylvania Medical Society and held this position from 1909 until his death. He was an enthusiastic supporter of tumor clinics as a means of improving the care of the cancer patient and he organized in 1926 at the Moses Taylor Hospital in Scranton the first tumor clinic in Pennsylvania and one of the early ones in the country.

The Wainwright Tumor Clinic Association is an organization of Pennsylvania hospital tumor clinics. Membership is by hospital and each hospital is allowed two physicians to represent that hospital. In 1963 membership was enlarged to include individual pnhsicians with an interest in cancer. There are now sixty-nine hospital members and eighty-two individual members.

The objectives of the association as stated in the constitution are:

(1) To promote the organization and development of approvable hospital cancer programs.
(2) To collect information on hospital cancer programs in Pennsylvania.
(3) To discuss theories and facts concerning the prevention, diagnosis and treatment of cancer.

(4) To disseminate cancer knowledge among the professions and the laity.

The association holds an annual meeting to discuss the diagnosis, treatment and prevention of cancer and to discuss problems in the operation of tumor clinics and tumor registries.

In addition to these annual meetings the association has been active in promoting more and better tumor clinics and tumor registries. In 1961 and 1962 a survey was made of tumor clinics and tumor registries with the object of detecting deficiencies and recommending corrective action. The chief fault found was failure to make use of registry data for evaluation of treatment.

In order to stimulate more use of registry data the association is sponsoring a program which permits comparison of five-year survival record at all participating hospitals. Names of hospitals are not revealed but, by the use of code numbers, each hospital can compare its survival experience for selected cancers with all others.

Another Wainwright program provides consultants to visit tumor clinics. This program has been supported by a grant from the Public Health Service. Consultants are Liaison Fellows of the American College of Surgeons and they aim to improve the functioning of tumor clincs and tumor registries by making periodic visits.

Anyone desiring information concerning membership in the association should write to the Executive Sectretary, Hugh R. Gilmore Jr., M.D., P.O. Box 90, Harrisburg, Pennsylvania 17120.

Nothing new under the sun

If You Can Find The Sun

Pollution, a serious threat to all life forms, is not a new problem, although it is difficult to imagine that it ever was as much at a crisis point as now. Read the following quotations and learn that there really is nothing new under the sun—when you can see it through the smog.

"Thus often when one's country air is
blown
Into another, and forsakes its own;
It spoils the wholesome air, where'er
it goes,
And, like itself, makes all unfit for us."

De Rerum Natura, Bk. VI
Lucretius [96?–55 B.C.]

"Languor seizes the body from bad ventilation."

Ars Amatoria, Bk. II
Ovid [43 B.C.–A.D. 17?]

"The conjunctival irritations of the eyes, which are caused by smoke, over-heating, dust or similar injury, are easy to heal; the patient being advised first of all to avoid the irritating causes; next, to bathe the eyes, in the beginning with lukewarm water, later with cold, also to avoid bright light. For the disease ceases without the use of any kind of medicine, if only a proper way of living be adopted."

Tetrabiblon, Ch. 3
Aetios [ca. 535]

An Even Break For The Fetus

To smooth out the inequalities in human life, produced by the slings and arrows of outrageous fortune, has not previously struck me as one of the functions of the physician. But to give all men an equal deal in the game of life is a natural human aspiration and all men are certainly *not* born equal in most respects.

This is pointed out in the opening paragraph of a highly useful review of the enviornmental factors which produce fetal malformations, published in this issue. Dr. Fred B. Nugent of Reading has given us a very practical discussion of a subject about which many of us need more fundamental instruction and review.

Most physicians have been aware that the knowledge of genetics has advanced in an almost miraculous fashion in recent years. But many of us have not kept pace with the advances. PENNSYLVANIA MEDICINE is proud to offer this convenient opportunity to make a solid advance in understanding by means of a small expenditure of time and effort.

Dr. Nugent's review takes up the subject of the abnormalities which are not explained on a strictly hereditary basis. The causes of fetal malformations which exist in our environment are more immediately apparent to both doctor and patient and have had a great deal of exposure in the public press since the thalidomide affair and the discovery of the effects of viral infections of maternal tissue upon the offspring.

It may not strike the potential reader that this paper will make a practical return of time invested in reading, since there is no magic medication to wipe out the defect. But, ptophylaxis is still a most important branch of therapeutics and counseling the patient must be based on full understanding and modern information. These we are proud to present to you in a well prepared package.

CBL

Doc, I'm referring you to a pro at Brandywine...He's a specialist in woods.

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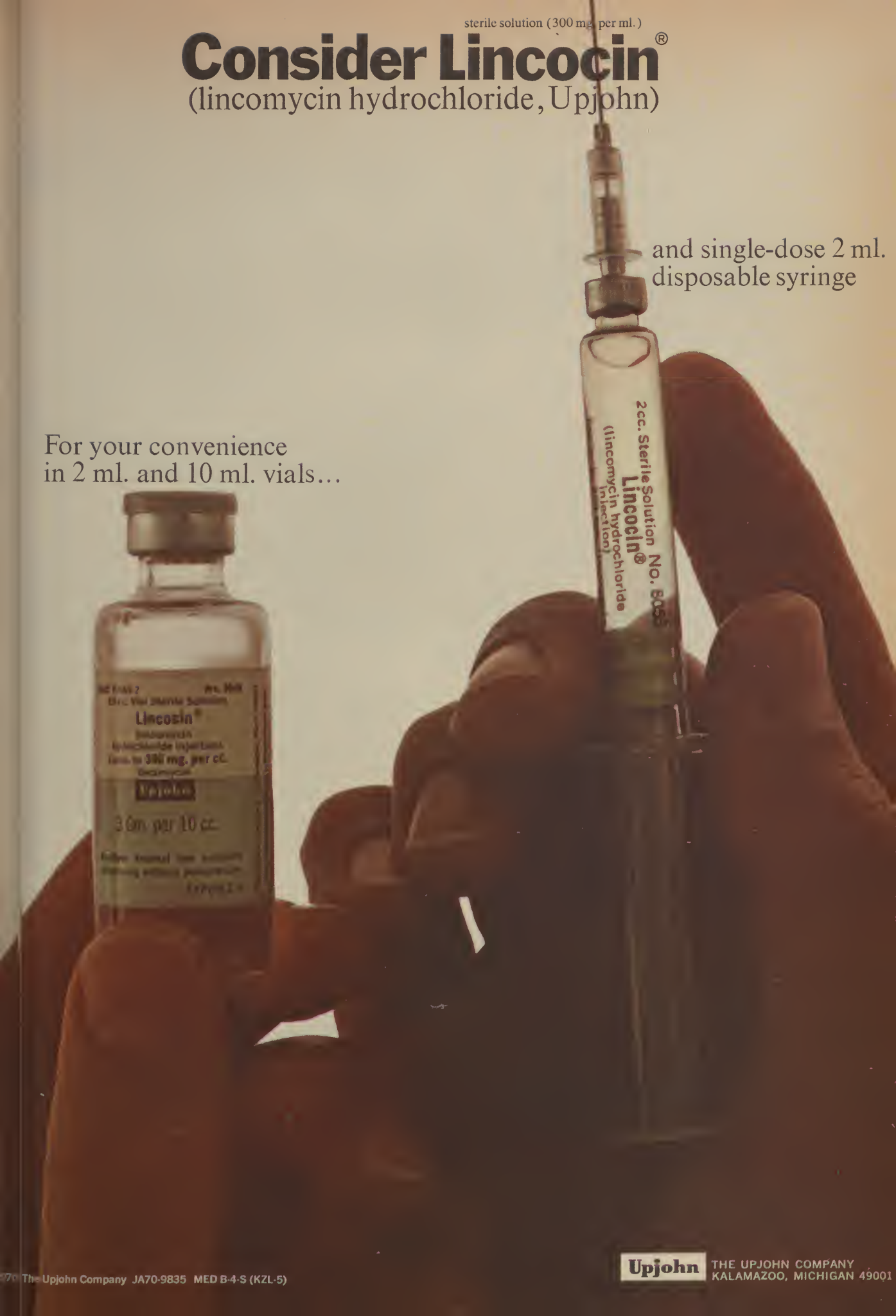
Consider Lincocin®

(lincomycin hydrochloride, Upjohn)

and single-dose 2 ml.
disposable syringe

For your convenience
in 2 ml. and 10 ml. vials...



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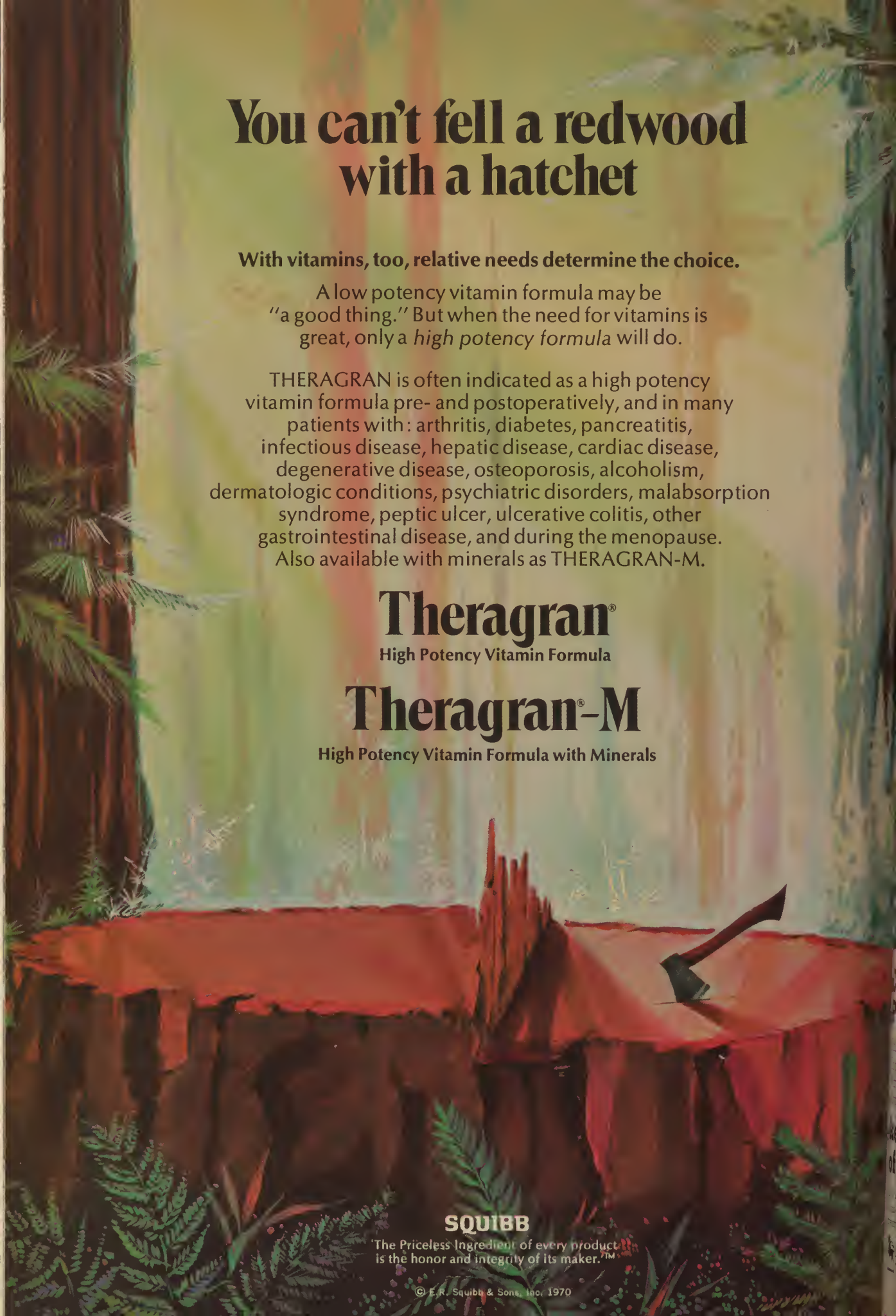
You can't fell a redwood with a hatchet
With vitamins, too, relative needs determine the choice.
A low potency vitamin formula may be "a good thing." But when the need for vitamins is great, only a high potency formula will do.
THERAGRAN is often indicated as a high potency vitamin formula pre- and postoperatively, and in many patients with: arthritis, diabetes, pancreatitis, infectious disease, hepatic disease, cardiac disease, degenerative disease, osteoporosis, alcoholism, dermatologic conditions, psychiatric disorders, malabsorption syndrome, peptic ulcer, ulcerative colitis, other gastrointestinal disease, and during the menopause. Also available with minerals as THERAGRAN-M.
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nce-popular treatment for back pains
s to have the seventh son of a seventh son
nd or walk on the patient's back.

The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

eadache, a sovereign remedy was
ear a snakeskin round one's head.

A realistic approach to pain relief

Empirin®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

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Rockahoe, N.Y.

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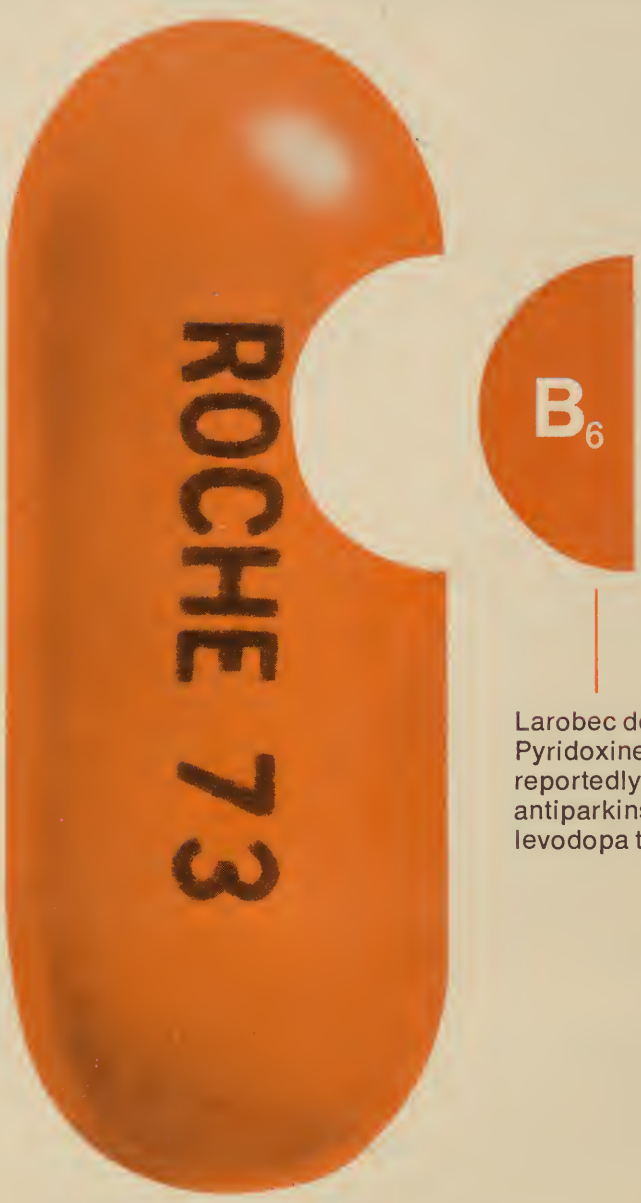
SPECIFICALLY FOR LEVODOPA PATIENTS—NUTRITIONAL SUPPORT WITHOUT PYRIDOXIN

Larobec provides: B-complex vitamins, of particular importance to the patient who is on levodopa therapy and is deficient in water-soluble vitamins.

Larobec provides: Ascorbic acid, useful in assisting tissue repair in the debilitated patient.



Larobec does *not* provide: Pyridoxine (vitamin B_6)—whic reportedly reverses the antiparkinson effects of levodopa therapy.[1,2]

Larobec™ Tablets

A high-potency nutritional supplement specific to the needs of patients with Parkinson's disease and syndrome on levodopa therapy—that describes new Larobec™ from Roche. Larobec provides the major B vitamins plus vitamin C—*but does not provide pyridoxine.* Thus, with its specially tailored formula, Larobec assures the patient important nutritional support without minimizing any of the benefits of levodopa therapy.

1. Duvoisin, R. C.; Yahr, M.D., and Coté, L. D.: *Trans. Amer. Neurol. Assoc., 94*:81, 1969.
2. Cotzias, G. C.: *J.A.M.A., 210*:1255, 1969.

Complete Prescribing Information:
Each Larobec tablet contains:
Thiamine mononitrate (vitamin B_1) 15 mg
Riboflavin (vitamin B_2) ..... 15 mg
Niacinamide .....100 mg
Calcium pantothenate ..... 20 mg
Cyanocobalamin (vitamin B_{12}) ... 5 mcg
Folic acid ..... 0.5 mg
Ascorbic acid (vitamin C) .....500 mg

Description: For prophylactic or therapeutic nutritional supplementation concomitant with levodopa therapy in patients with Parkinson's disease and syndrome, Larobec provides high potency dosages of the major B-complex vitamins, without pyridoxine (vitamin B_6) which has been reported[1,2] to reduce the clinical benefits of levodopa therapy. B-complex vitamins are essential in the anabolism of carbohydrate and protein and in hematopoiesis. Larobec also contains therapeutic quantities of ascorbic acid, a substance involved in intracellular reactions such as tissue repair and collagen formation.

Indications: Larobec is indicated for supportive nutritional supplementation when a water-soluble vitamin formula (without pyridoxine) is required prophylactically or therapeutically in patients under treatment with levodopa.

Warning: Administration of vitamin B_6 may be required if signs of pyridoxine deficiency develop. Larobec is not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.

Dosage and Administration: One or two tablets daily, as indicated by clinical need.

How Supplied: Orange-colored, capsule-shaped tablets, imprinted Roche 73; bottles of 100.

References:

1. Duvoisin, R. C., *et al.*: *Trans. Amer. Neurol. Assoc., 94*: 81, 1969.
2. Cotzias, G. C.: *J.A.M.A., 210*:1255, 1969.

high-potency nutritional support for the levodopa patient

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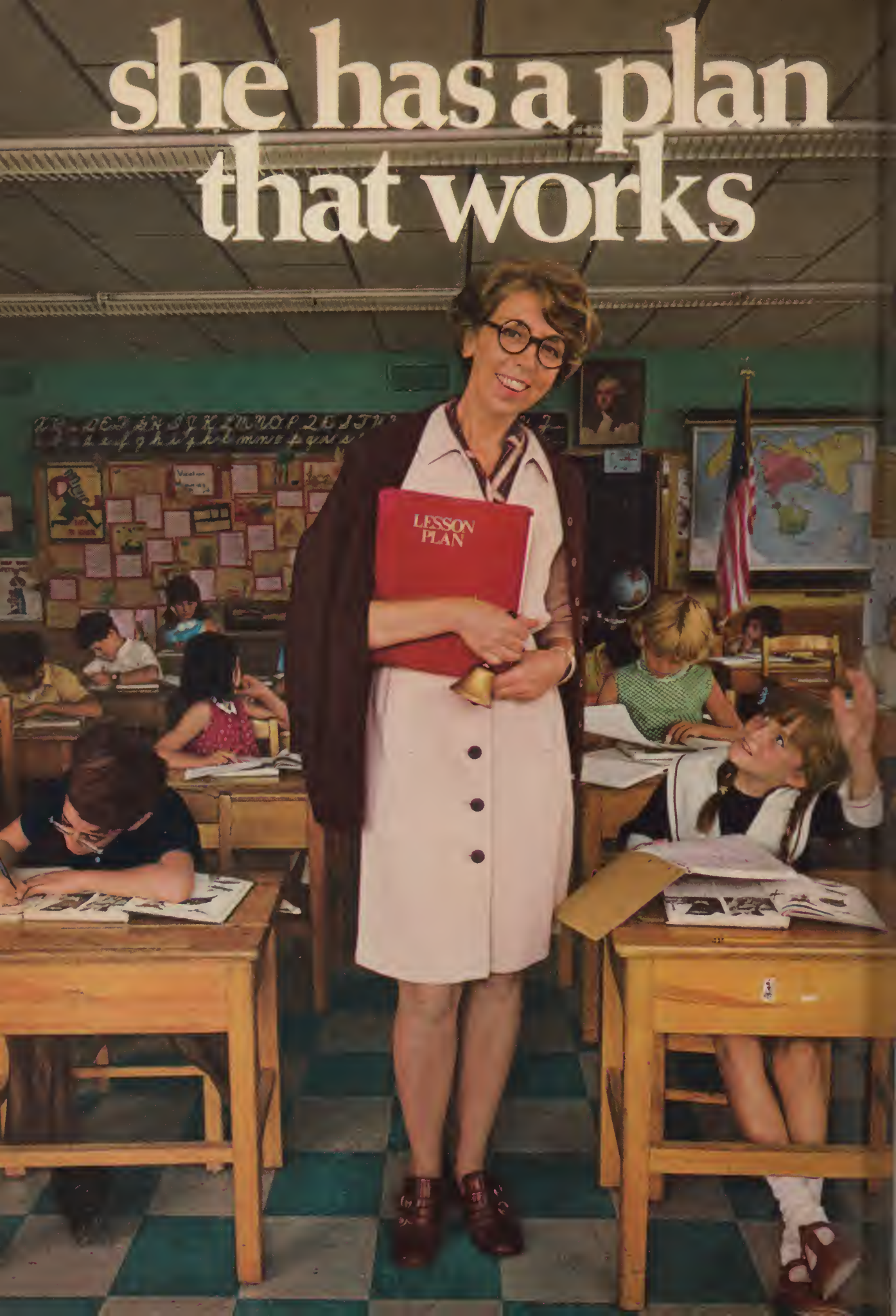

she has a plan
that works
LESSON
PLAN

She has a plan that works.

She has one plan for the class. And they really respond.

She has another plan just for herself. A medication plan for her hypertension. And she's also responding beautifully.

More than just another antihypertensive, Ser-Ap-Es can be a whole medication plan for living with hypertension.

Does it get good marks for comfort?

Excellent. Because Ser-Ap-Es controls blood pressure effectively, dosage of each component is lower than if prescribed alone, usually minimizing side effects. However, side effects may occur (see prescribing information).

Designed with the kidney in mind?

Hydralazine maintains or increases renal blood flow.

And the brain too?

Hydralazine also relaxes cerebral vascular tone. And reserpine has beneficial calming action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

Practical on a teacher's salary?

Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits…

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

CIBA

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

a plan for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

INDICATIONS: All cases of hypertension except the mildest and the most severe.

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

Hydralazine: Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Reserpine: The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydralazine: Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

Hydralazine: Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and nonrigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Reserpine: Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

Hydralazine: Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

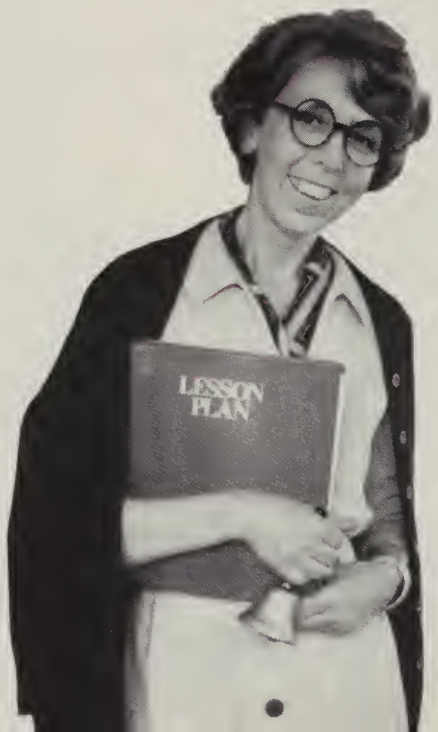
DOSAGE: One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

SUPPLIED: *Tablets* (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Summit, New Jersey

2/4624

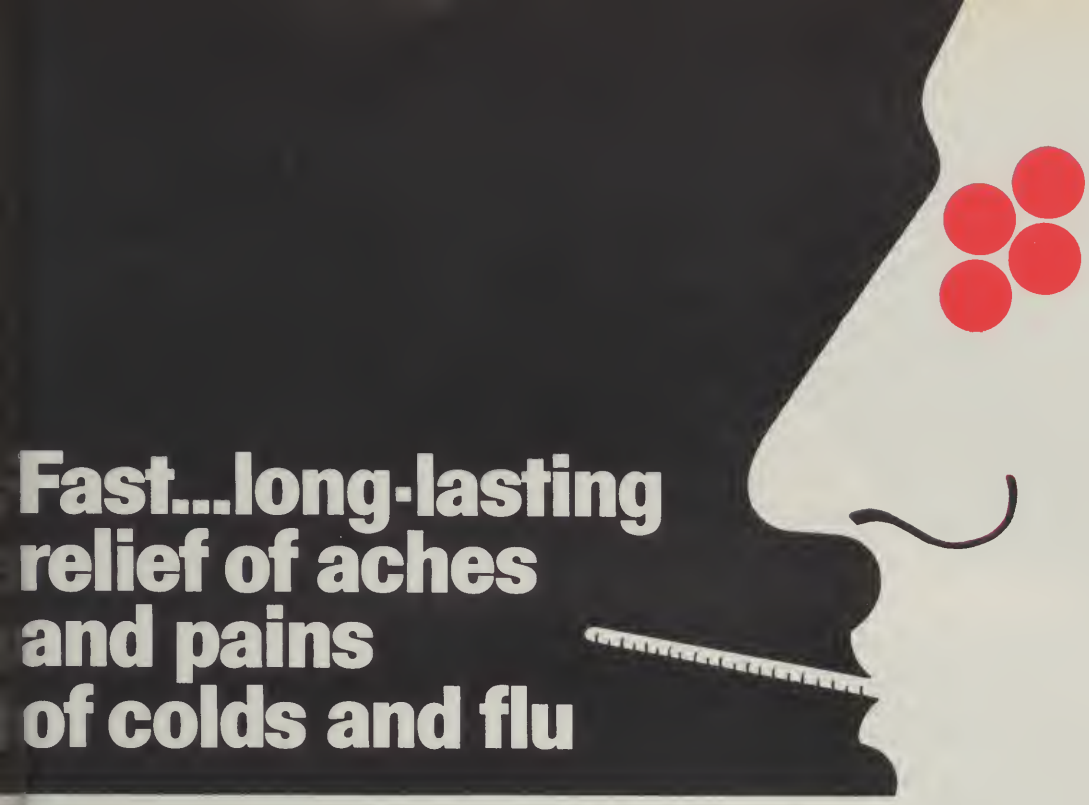


she has a plan that works for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

CIBA



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Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.
Available: Bottles of 12, 36 and 60 tablets.

2
3
4
5
6

the night shift of depression... insomnia

Depression is a 24-hour-a-day problem. And insomnia is often its nocturnal expression. In fact, insomnia may be a key symptom in establishing the diagnosis of depression.

ELAVIL HCl (Amitriptyline HCl, MSD) may prove quite helpful when you have arrived at such a diagnosis. Unlike psychic energizers or agents that merely elevate mood, ELAVIL HCl embodies a mild antianxiety action which manifests itself even before the fundamental antidepressant activity of the drug becomes evident. Daytime drowsiness occurs in some patients, usually within the first few days of therapy.

NOTE: Not recommended during the acute recovery phase following myocardial infarction. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

Contraindications: Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of monoamine oxidase inhibitor. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

Precautions: When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be exacerbated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as perphenazine, concurrently.

When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, and 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives.

For more detailed information, consult your MSD representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

when the diagnosis is depression

ELAVIL® HCl
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Experiment in Rural Planning Begins

Integration of social planning with physical planning in rural areas is the intent of a new project being conducted jointly by private and governmental organizations in a contract supported by the Office of Economic Opportunity. Community Services of Pennsylvania (CSP), the statewide citizen planning organization in health and welfare, supported by United Funds, has joined with the Pennsylvania Department of Community Affairs (DCA) and Pennsylvania State University in a project aimed at extending social planning services to Appalachian and other disadvantaged Pennsylvania regions. The project is also aimed at providing assistance to local organizations in obtaining a more equitable share of local, state, and federal resources for the solution of health and welfare problems.

Under the $111,000 contract, four rural planning specialists will be hired for assignment to counties which do not now have the benefit of health and welfare planning structures such as Community Action Programs or Health and Welfare Planning Councils. Penn State will provide a team led by a rural sociologist to evaluate problems and progress under the contract. The contract will run for one year, with an option for extension for a second year to be negotiated.

A unique aspect of this experiment is its built-in comparison between the rural planner working with planning commissions, as contrasted with the two specialists operating as free agents with supervision and backup support from CSP in Harrisburg. Funds are being provided to two planning commissions through DCA. One of the DCA specialists has been assigned to the Northern Tier Regional Planning Commission. The other rural planner will work with the Snyder-Union County Planning Commission.

Working under the direct supervision of the planning directors in these two agencies, the specialists will provide the social planning component to the overall plans and programs of the planning commissions. One of CSP's specialists will work with leaders and organizations in Northumberland County, while the other will serve an area yet to be chosen.

CSP began planning for a program to combat rural poverty in 1969. DCA was at the same time considering ways to incorporate social planning into the physical planning agencies in rural areas. A joint project proposal was submitted in April, 1970, by the two organizations to the Federal Region III Office of Economic Opportunity. OEO announced funding of the project in August, 1970.

Throughout the process of developing this project, CSP and DCA maintained constant communication with interested agencies and organizations, including the State Society.

While social planning is becoming a major part of the operations of urban and suburban planning commissions, in the rural areas of the state it is a recognized necessity they cannot afford. Thus, one of the problems of rural areas is a lack of knowledge in tapping local, state, and federal resources which could aid in the closing of gaps in critical health and social services.

The rural planning specialists will be expected to work toward the goals of developing and improving health and welfare services to residents of the rural areas they serve, and establishing models which could be used in other rural areas across the state. To accomplish this, they must establish communications and working relationships with existing local public and private agencies, organizations and individuals, including state and federal agency representatives working in those areas.

They will then develop profiles of problems, service gaps, and health and welfare needs of their respective areas. This can be derived both from local agencies and organizations, and through direct contact with residents. The rural planners will deal directly with local citizens about the needs of the area, the problems, and the programs and services that should be developed to meet those needs.

In addition to the actual planning services provided to rural areas, the project is also expected to demonstrate the effectiveness of a joint effort between state-level private organizations, state and local agencies, and a major university. This is the first such demonstration project funded by the Office of Economic Opportunity.

Let George Say It

Reflections On The Feast Of The Circumcision

GEORGE A. ROWLAND, M.D.
Millville

Thirty years ago a whole series of off-color stories dealt with the observable difference in presence or lack of foreskin between Christian and Jewish males. Racism of this sort has now ceased to exist. Circumcision is now so well established in every maternity hospital that interns and medical students examining older men frequently make the notation "Uncircumcized" as if this was a variation from normal.

We pride ourselves on our scientific honesty today. Learned committees are busy discarding drugs whose worth cannot be entirely defended. Experts refuse to give patients medication until a specific diagnosis is made and yet esteemed obstetricians who otherwise never touch a male patient daily perform this ritual maiming.

It is not very clear how this situation arose. Excuses for the procedure used to start with the prevention of cervical carcinoma. This, of course, did not apply to the defenseless object but hopefully to his possibly unborn future wife. Real scientific proof has so far failed to support this interesting theory. Another rationale, of course, is the prevention of cancer of the penis. This is probably true but this condition is scarcely of pandemic proprotion. A far better case for this type of procedure could be made for prophylactic mastectomy of young girls.

When really cornered, avid prepuce clippers mumble something about cleanliness and doing away with phimosis. Surely instruction in sanitary care could avoid this need. The only other defenders are psychiatrists who say the operation improves sexual function. As with many psychiatric indications, there are experts who hold the opposing view.

Thirty years ago, when interns were rewarded only by room and board by generous hospitals, circumcision fees were a windfall to them. I believe this may have been the origin of the present mania. Today with emoluments approaching $1,000 a month, even that reason is no longer tenable.

A few years ago, convinced that there was no defensible reason for this multilation of babies, I decided to discontinue the procedure in my small obstetrical practice. It rapidly became apparent that this change was not socially acceptable. My colleagues could have cared less. The nursing staff felt that my approach was unorthodox and therefore somehow improper. The biggest obstacle, however, turned out to be the little boys' mothers. Almost to a girl they demanded that discrimination not be applied to their babies. They all knew that just as cocker spaniels should have their tails bobbed, little boys should be freed of their foreskins.

I have finally solved my problem by retiring from the practice of obstetrics. I still feel badly about the little boys. I hope somebody will prove this needs to be done or else put a stop to the whole business.

PENNSYLVANIA MEDICINE correspondence

Jefferson Medical College
Philadelphia, Pa.
December 10, 1970

To the Editor:

Dr. George Rowland in his editorial "Getting into Medical School" in the November 1970 issue of PENNSYLVANIA MEDICINE paints a rather dismal picture of medical school admissions. I offer him a standing invitation to attend a Committee on Admissions meeting, held every Wednesday from 12:00 noon to 2:30 p.m., to learn how Jefferson Medical College functions in admissions. Although I cannot speak for the other Pennsylvania medical schools, to my knowledge their admissions criteria are similar to ours.

No student is admitted into Jefferson without recommendations. No student is admitted without an interview. Selection is based on personal qualities and academic proficiency; both are important and must be of high caliber. We do not offer admission for strong personal qualities in lieu of adequate academic performance, nor do we accept performance in lieu of personal attributes.

Perhaps when Dr. Rowland visits us he can aid us in the difficult task of admissions. Perhaps he will discover a different orientation than he now envisions.

Sincerely yours,

Samuel S. Conly, Jr., M.D.
Associate Dean and
Director of Admissions

Board of Trustees Acts on House of Delegates Referrals

The following Board of Trustees actions are the result of referrals from the 1970 House of Delegates Annual Session.

1. **Resolution 70-22: Drug Abuse (Second Resolve)**

"RESOLVED, That the Pennsylvania Medical Society assist the Commonwealth of Pennsylvania in developing a well-coordinated, effective educational program bringing together, as much as possible, the many groups now presently making a contribution to this vast educational effort."

The Chairman of the Board referred this resolution to the Council on Education and Science. The Commission on Mental Health and Mental Retardation, in cooperation with the appropriate state agencies and the P.A.G.P., is currently exploring the possibility of establishing a series of regional seminars to inform physicians about drug abuse and appropriate treatment.

2. **Resolution 70-14: Noise Pollution**

"WHEREAS, There are implements commonly used such as lawn mowers, power saws, etc. that produce noise levels above a safe point; now therefore be it

"RESOLVED, That the Pennsylvania Medical Society encourage the initiation of legislative and educational measures to notify purchasers of these implements of their potential dangers and how these dangers might be minimized."

The Chairman referred this resolution to the Council on Education and Science; the Council's Commission on Environmental Health plans to contact the Pennsylvania Society of Ophthalmology and Otolaryngology which has a commission studying the problem of noise, in order to obtain the information necessary to formulate legislation or educational procedures.

3. **Resolution 70-11: First Aid Training for High School Students**

"RESOLVED, That all high school students be offered a first aid course similar to the American Red Cross Standard Course or the Civil Defense Medical Self Help Training Course prior to graduation from high school."

The Chairman referred this resolution to the Council on Education and Science. The Commission on School Health will discuss this resolution at its next meeting.

4. **Resolution 70-23: Bicentennial of the Independence of the United States of America**

"RESOLVED, That the President of the Pennsylvania Medical Society and the Board of Trustees be urged to support all medical activities relevant to the Bicentennial celebration in Philadelphia, in order that these groups may cooperate in every possible way in developing plans to display the past, present and prospective aspects of all health-related services; and be it further

"RESOLVED, That the Pennsylvania Medical Society give whole-hearted endorsement to the Bicentennial celebration and to the extending of invitations to national and international societies that have not already done so to participate in the celebration; and be it further

"RESOLVED, That the Board of Trustees of the Pennsylvania Medical Society consider means, funding and implementation of such plans as may be instituted by this Society. . ."

The Chairman referred this resolution to the Council on Public Service, which has appointed a special committee to study the State Society's involvement in the Philadelphia Bicentennial.

5. **Medical Education, Including Non-Technical Aspects of Health Care**

The House accepted a recommendation that medical education should be more relevant to the social needs of citizens. To that end, the House directed that each SAMA chapter be asked to designate a representative to meet with an appropriate committee of the Society to develop a specific program for implementation and submission to medical schools.

The Chairman referred this recommendation to the Council on Public Service. The Council has recommended to the Board that the Council's Advisory Committee on Students, Interns and Residents, arrange a meeting with a representative from each of the seven SAMA chapters to discuss this approved recommendation.

6. **Board Supplemental Report A: Licensed Practical Nurse Act**

The House directed that the Society meet with appropriate representatives of the nursing profession to review the concept that some form of nurse training can be instituted through the vocational-technical high schools in the Commonwealth, possibly academic study at the twelfth grade level with clinical training being undertaken as a post high school subject. The House also authorized the Board of Trustees to introduce legislation to change the requirements of the Licensed Practical Nurse Act if so recommended as the result of the study by the Committee on Relationships with Allied Professions.

The Committee on Relationships with Allied Professions met with appropriate representatives of the nursing profession on September 24 and 25. After careful study, it was the Committee's opinion that this proposal represents a weakening of the qualification standards and consequently, the Committee has recommended to the Board of Trustees that no legislation be sponsored to change the standards in the Licensed Practical Nurse Act.

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Contraindications: Known sensitivity to sulfonomides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
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Codeine phosphate	10.0 mg.
(warning: may be habit forming)	
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Non-narcotic for 6-8 hr. cough control

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Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
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Alcohol, 1.4%	

Clears sinuses and nasal stuffiness as it relieves cough

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Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
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ROBITUSSIN A-C®	●	●			
ROBITUSSIN-DM®	●		●		●
ROBITUSSIN-PE®				●	●
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Not too little, not too much... but just right!

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Erythromycin Estolate

(equivalent to 250 mg. of base per 5-ml. teaspoonful)

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly

100204

Medical Management of The Alcoholic Patient

David A. Smith, M.D., Medical Editor
Harrisburg

Office Treatment

The present misunderstanding of alcoholism is characterized as a chronic disabling disease of unknown etiology with physiological, psychological and sociological disturbances which impairs an individual's ability to function in a normal, acceptable manner. As with other chronic diseases of unknown etiology, the goal of therapy is to maintain the individual as close to a normal physiological and functioning state as possible, similar to patients who suffer from other chronic illness such as diabetes, emphysema, coronary heart disease, peptic ulcer, and colitis. As with these latter ailments, the physician must accept the fact that chronic alcoholics under treatment may relapse. Therefore, the goal of therapy is also to decrease the periods of exacerbation of the illness (both the frequency and the duration) and to increase the periods of normal functioning as much as possible.

Diagnostic Clues

Early detection of the chronic alcoholic is difficult and only by physician awareness to a potential drinking problem can early treatment be attempted.

The following "clues" taken from the *AMA Manual on Alcoholism* serve to arouse the physician's suspicions.

1. Increasing consumption of alcohol, whether on a regular or sporadic basis, with frequent and perhaps unintended episodes of intoxication.
2. Drinking as a means of handling problems or relieving symptoms.
3. Obvious preoccupation with alcohol and the expressed need to have a drink, especially if habitually repeated.
4. Refusal to concede what is obviously excessive consumption and expressing annoyance when the subject is mentioned.
5. Frequent absenteeism from the job, especially if occurring in a pattern, such as following weekends and holidays (Monday morning "flu").
6. Repeated changes in jobs, particularly if to successively lower levels, or employment in a capacity beneath ability, education and background.
7. Persistent marital and family problems, perhaps with multiple marriages.
8. Coarse, unexplained tremors of the hands.
9. Poorly explained contusions and abrasions in various stages of healing, except in the elderly.
10. Gastritis or duodenal ulcer which fails to respond to usual therapy.
11. Palpable, non-tender liver.
12. Obvious evidence of inappropriate use of alcohol, such as in the hospital or before an office appointment.

Diagnosis

The definition of a chronic alcoholic is any person who because of the ingestion of alcoholic beverages has difficulty in functioning in a normal and acceptable manner in his environment. In the early stages of the disease, the patient is more amenable to accepting a diagnosis of "a drinking problem." In the latter stages, he is usually able to accept the diagnosis of "chronic alcoholism." Once an area of disturbance has been delineated the physician should discuss with the patient:

1. Acceptance of the fact that drinking has caused or is aggravating his special situation.
2. That the first goal of therapy is TOTAL ABSTENTION from alcoholic beverages to remove the effects and influence of drinking on this specific problem.
3. Should the patient be unable to totally abstain from the intake of alcoholic beverages in the presence of a disturbed situation the diagnosis of chronic alcoholism is sustained.

Treatment

To assist the patient to totally abstain from alcohol, the physician should give him both pharmacological as well as psychological help. The use of medication should be restricted to the mildest form of drug necessary and should be given with the understanding that the withdrawal period is a self-limiting period and that once the patient has been withdrawn from alcohol, there is no need for the sustained full dosage of medication as prescribed during the withdrawal period. There are no drugs of choice for the treatment of alcoholism, thus, two regimens are listed as examples, for the physician's choice:

If the patient has not been eating properly or if gross tremors are

present, parenteral vitamins may be utilized:

Intramuscular: Vitamins B1 and B6 = 100 mgs. and Vitamin B12 = 1000 mcgms.

Oral: B Complex in larger doses (e.g. Allbee with C, Stresscaps) or therapeutic formulas of multivitamins.

Antabuse

The use of Antabuse when properly explained to patients can be of great value during the withdrawal period. They should be cautioned against taking any alcoholic beverages or liquids containing alcohol such as mouth washes, cough syrups, elixirs, tonics, etc. If there is any doubt, the patient should be instructed to call the doctor or pharmacist to be certain there is no alcohol present in the preparation. The patient should be cautioned not to attempt to drink for at least 4-7 days after the last Antabuse pill.

CONTRAINDICATIONS FOR ANTABUSE: There are no contraindications for the use of Antabuse under proper supervision except:

1. Psychotic or emotionally disturbed patients with suicidal tendencies.

2. A skin reaction which necessitates discontinuance of the drug.

SIDE EFFECTS OF ANTABUSE

1. Gastric Irritation — which can be minimized by taking the medication after a meal or with an antacid.

2. Metallic or "funny" taste — Reduce the dose to ¼ tablet per day usually given at h.s. or after the evening meal.

Follow-Up Care

The goal of therapy is to maintain the patient as close to a normal physiological and functioning state as possible. The physician should 1) see the patient as often as necessary to maintain the psychological support and reinforcement of total abstinence, and 2) *accept the fact that relapses can occur, and a goal of therapy is to decrease the frequency and duration of these relapses;* and 3) acquaint himself with the various agencies and groups available in the community to assist him such as Alcoholics Anonymous, local health departments, and local alcoholism councils.

Medications

DRUG	STRENGTH	FREQUENCY	REMARKS
Sparine	50-100 mgm.	q.i.d.	for one week
Meprobamate	400 mgm.	q.i.d.	for one week
Benadryl	50 mg.	h.s.	for sleep
Noludar	300 mg.	h.s.	for sleep
Phenergan	12.5-25 mgm.	h.s.	for sleep

The Hospitalized Alcoholic

Ordinarily the chronic alcoholic is hospitalized for withdrawal after prolonged use of alcohol. Not infrequently he may be too physically ill as the result of an intercurrent infection, a neurological or digestive complication of his alcoholism or head injury to continue drinking. In any event, the patient presents himself often enough as an emergency situation in which rapid deterioration of his physical condition may occur and for which the physician must be prepared to detect and treat.

Diagnostic Information

A careful history must be obtained from whatever source is available — patient, family, friend, or ambulance attendant — as to the precipitating cause for admission. A history of injury, physical illness and drinking patterns will frequently avoid delays in diagnosing complications when the patient's stuporous state, inability to recall events, or acute brain syndrome precludes a dependable history from the patient. *A physical examination must be performed as soon as possible because of the likelihood of life-threatening complications.*

Most patients begin to react from their acute alcoholic intoxication within six hours after admission. If the patient has not reacted — head injury, an alcoholic gastrointestinal complication, or intercurrent infection must be considered and appropriate diagnostic measures and treatment instituted as early as possible.

The following guidelines for admission to a general hospital were adopted by the AMA House of Delegates in 1956 and reaffirmed in 1966. They are offered to re-emphasize the need to recognize the various medical emergencies that occur in the alcoholic.

1. A patient who is diagnosed as "alcoholic" by a physician, or who is so known by the hospital or by other responsible agencies and individuals, should be admitted if he:
   a. has an infectious disease.
   b. has hyperthermia.
   c. has a history of convulsions, or a poorly controlled convulsive disorder and has been drinking.
   d. is hemorrhaging or unconscious.
   e. wants to be withdrawn from alcohol, either for the first time or after having relapsed to drinking.
   f. has a disulfiram — alcohol reaction.
2. A person who is diagnosed as "alcoholic" by a physician, or who is so known as an alcoholic patient, as the case may be, when he:
   a. is unconscious and has been drinking.
   b. is agitated and tremulous to the extent of indicating an acute withdrawal syndrome.
   c. has convulsions, hallucinations or delirium tremens, manifesting a complicated withdrawal state.
   d. is suffering from a disease recognized as related to alcoholism (e.g., cirrhosis, neuropathy, pancreatitis) and wishes to be withdrawn from alcohol.
   e. has a disease or posttraumatic injury usually not requiring hospitalization, but also has a history of prolonged drinking, or of heavy ingestion of alcohol immediately prior to the illness.

Treatment

Since there is no known medication which aids in the removal of alcohol from the blood stream, one must wait until the body has metabolized the ingested alcohol before sobriety can be achieved. Deepening coma must alert

the physician to some associated complication.

The choice of specific medications for the management of withdrawal from alcohol should be based upon the physician's experience and knowledge of that medication.

The following regimen is suggested for the acutely intoxicated alcoholic requiring hospitalization. The patient should be closely supervised by nursing personnel to see that the medications, fluids, food, etc. are taken by the patient as prescribed.

1. Promazine Hydrochloride (Sparine,® Wyeth) 50 to 100 mg. p.o. q.i.d. for the first 3 days, 25 mg. p.o. q.i.d. for next 2 days, then discontinue.
2. Phenobarbital grains ½ t.i.d. X first three days, grains ¼ t.i.d. for next two days, then discontinue if no signs of impending seizures.
3. Thiamine 100 milligrams
   Vit. B 12 100 micrograms
   Niacine 50 milligrams
   Vit. C 250 milligrams
   I.M. daily X five days
4. High potency multivitamin (Theragran-M Tablets,® Squibb) t.i.d. p.o. X five days and once daily thereafter.
5. Thiamine 100 milligrams p.o. t.i.d. X five days.
6. Chloral Hydrate 0.5 grams at h.s. and repeat in two hours if necessary.
7. Parenteral fluids if needed for vomiting and dehydration.
8. Force oral fluids, particularly orange juice, also other juices, broth and milk. Regular diet as tolerated.
9. In event of definite signs of seizures or hallucinations give Librium 50-100 mgm. I stat and q2-4h prn.
10. If agitation is not adequately controlled, increase phenobarbital to one grain q.i.d. X two days then taper as described in order No. 2.
11. Prochlorperazine (Compazine,® SKF) 10 mgm. IM q6h for vomiting.
12. Robaxin® (Robins) 500 mg. 2 tablets q.i.d. for 2 days, then 1 tablet q.i.d. thereafter for severe muscle tremors.

Once withdrawal has been completed, the physician should proceed with plans for post-hospital care.

Dr. Smith, recently appointed medical editor of PENNSYLVANIA MEDICINE, is immediate past president of the Dauphin County Medical Society. He is director of internal medicine at Harrisburg Polyclinic Hospital.

General

Hospital staff attitudes toward the patient assume great importance. The patient, more often than not, presents himself in a partially drunken state, unkempt, hostile, demanding or combative. Staff acceptance of the patient's condition will materially aid in gaining patient cooperation and lessening staff resistance. Most of these patients can be adequately handled on a general medical service and tend to sleep after a tranquilizer has been given; when agitation subsides, patient handling is rarely difficult and differs but little from the ordinary medical patient. Restraints should be avoided except as a last resort. Seclusion is rarely necessary. As with other physical ailments, the same skills, judgment and concern are required in the care of the patient suffering with chronic alcoholism.

Hospitals Offering Alcoholism Treatment Programs

ALTOONA

ALTOONA HOSPITAL ALCOHOLISM CLINIC
Altoona, Pa. 16603
Director Med. Service: David Bishop, M.D.
Phone: 946-0334; 944-0811

BUTLER

RENE STACY MENTAL HEALTH CENTER
22 Hillvue Avenue
Director: R.L. Eisler, M.D.
Phone: 287-0791-2-3

DANVILLE

DANVILLE STATE HOSPITAL—ALCOHOLIC REHABILITATION CENTER
Danville
Superintendent: Dr. R.L. Watski
Phone: 217-275-3330

ERIE

ST. VINCENT'S HOSPITAL—COUNSELING CENTER FOR ALCOHOLISM
32 West 25th Street
Administrator: Dr. Walter Finken
Phone: 814-453-6911

FAIRVIEW

PINE GROVE ASSOCIATION (P.G.A.)
R.D. No. 2
Administrator: Zack Dennis
Phone: 814-474-5155

HARRISBURG

HARRISBURG STATE HOSPITAL, GATEWAY HOME
Pouch A
Director: D.B. Olewiler, M.D.
Phone: 717-238-7352

JOHNSTOWN

MERCY HOSPITAL
1020 Franklin Street
Administrator: Sister Mary Aubrey
Phone: 412-563-7511

LEBANON

PHILHAVEN HOSPITAL
R.D. No. 5
Administrator: J. Horace Martin
Phone: 717-273-8871

MEADVILLE

THE SPENCER HOSPITAL
Medical Director: Oscar Formati, M.D.
Phone:412-337-1261

NEW BRIGHTON

UNITED HOSPITAL OF NEW BRIGHTON

Medical Director: John Sutton, M.D.
Phone: 412-843-6000

PHILADELPHIA AND ENVIRONS

EAGLEVILLE HOSPITAL AND REHABILITATION CENTER
Eagleville, Pa. 19408
Administrator: Joseph J. Braun
Phone: 215-277-3030

HAVERFORD STATE HOSPITAL—ALCOHOLIC REHABILITATION UNIT
3500 Darby Road at College Avenue
Director: Mr. G. Griffith
Phone: 215-525-9260

MALVERN INSTITUTE
Box 297, Malvern
Psychiatrist: C. Nelson Davis, M.D.
Phone: 215-647-0330

NORRISTOWN STATE HOSPITAL
Norristown, Pa. 19401
In Charge: D.M. Cleaver, M.D.
Phone: 275-9700

SAUL CLINIC—STETSON HOSPITAL
1745 North 4th Street
Director: Jack L. Reavis
Phone: 215-PO9-1260

WAWA HOSPITAL—CUTLER CLINIC
Station Road, Wawa
Administrator: Lee Grimes
Phone: 215-GL9-3158

WILLOW GROVE HOSPITAL
Fitzwatertown Road, Willow Grove
Administrator: R.C. Stewart, M.D.
Phone: 215-OL9-2080

Outpatients Only

BRYN MAWR TREATMENT CENTER FOR ALCOHOLISM
9 Bryn Mawr Avenue
In Charge: Agnes M. Gedman, P.H.N.
Phone: 215-LA5-0810; LA5-3458

CROZER-CHESTER MEDICAL CENTER—ALCOHOLISM CLINIC
15th Street and Upland Avenue, Chester, Pa.
Director: Joseph M. Brill, M.D.
Phone: 215-TR4-8611

HAHNEMANN HOSPITAL—ALCOHOLIC CLINIC
1417 Race Street, Philadelphia, Pa.
Director: Peter E. Siegler, M.D.
Phone: 215-LO4-5000

PAOLI MEMORIAL—ALCOHOL TREATMENT CENTER
33 East Washington Street, West Chester, Pa.
Counselor: D.T. Morgan
Phone: 215-692-6114
Night: 296-5067

PITTSBURGH AND ENVIRONS

ALLEGHENY GENERAL HOSPITAL—ALCOHOLISM CLINIC
320 East North Avenue, Pittsburgh, Pa. 15212
Administrator: Regis M. Wolff, M.D.
Phone: 412-222-0100

HOMESTEAD HOSPITAL COMMUNITY MENTAL HEALTH CENTER
3409 Main Street, Munhall, Pa. 15120
Administrator: R. Henderson, ACSW
Phone: 412-461-2978

MAYVIEW STATE HOSPITAL
Bridgeville, Pa. 15017
Director: R.F. Downey, M.D.
Phone: 412-343-2700

McKEESPORT HOSPITAL
1500 Evans Avenue, McKeesport
In Charge: Miss H. Laughlin,
Mrs. Janet Gigler, Mr. Edward Bosanac
Phone:412-466-4000

MERCY HOSPITAL ALCOHOLISM CLINIC
Pride and Locust Streets, Pittsburgh, Pa.
Director: Charles Blair
Phone: 412-391-4495

ST. FRANCIS HOSPITAL—ALCOHOLISM TREATMENT CENTER
45th Street (off Penn Avenue)
Administrator: Dan Taylor
Phone: 412-683-6000

ST.JOHN'S HOSPITAL
3339 McClure Avenue
Administrator: James Daly
Phone: 412-766-8300

ST. JOSEPH'S HOSPITAL—OUTPATIENT ALCOHOLISM CLINIC
2117 E. Carson Street (South Side)
Administrator: Kenneth S. Ramsey
Phone: 412-481-0500

Outpatients Only

BRADDOCK GENERAL HOSPITAL
Holland Avenue
Director, Soc. Services: M.J. Manolios, ACSW
Phone: 412-351-3800

READING

ST. JOSEPH'S HOSPITAL—ALCOHOLISM CLINIC
Reading, Pa. 19603
Administrator: Wadim Kurjanowicz, M.D.
Phone: 215-376-8044

SCRANTON

Outpatients Only

SCRANTON STATE HOSPITAL OUTPATIENT CLINIC
Administrator: William Gallaso
Phone: 717-346-3960

SHARON

SHARON GENERAL HOSPITAL
740 E. State Street
Administrator: E.J. O'Meara
Phone: 412-981-1700

EAST STROUDSBURG

ENTAL HEALTH CENTER OF
ARBON-MONROE PIKE COUNTIES
)6 East Brown Street
Charge: Margaret D. Evermon, M.D.
ıone: 717-421-4000

WHITE DEER RUN

POCONO LAUREL LODGE
Pocono Lake, White Deer Run, Allenwood

Advisory Services
Councils, Committees, Outpatient Centers

The following list represents dedicated groups of citizens, private, professional or in government social agencies, which counsel and advise the alcoholic and his family, make referrals to medical or psychiatric, social or employment services which best fit the case. They do not "treat" alcoholism in the medical-clinical sense, but offer great help as sources of information, intercession and realistic guidance and in some cases outpatient care.

.COHOLISM COUNSELING CENTER
Stanton State Hospital
25 Mulberry Street
Stanton, Pa. 19503

.LENTOWN COUNSELING CENTER
FR ALCOHOLISM
Aentown Hospital Annex
24 N. 17th Street
Aentown, Pa. 18104

BAVER COUNTY COMMUNITY
NTAL HEALTH CENTER
10 Virginia Avenue
Rchester, Pa. 15074

BAVER COUNTY COUNCIL ON ALCOHOLISM
Biver County Mental Health Association
6: Third Street
Biver, Pa. 15009

BRKS COUNTY COUNCIL ON ALCOHOLISM
3 N. Fifth Street
Riding, Pa. 19601

BTHLEHEM COUNCIL ON ALCOHOLISM
5 Broad Street
Bhlehem, Pa. 18018

BCKS COUNTY ASSOCIATION
O ADDICTIVE DISEASES
36. Main Street
Dylestown, Pa. 18901

BAIR COUNTY COUNCIL ON ALCOHOLISM
P. Box 809
Aoona, Pa. 18103

BTLER COUNCIL ON ALCOHOLISM
Verans Administration Hospital
Bler, Pa. 16001

CRBON COUNTY CITIZENS ADVISORY
CMMITTEE ON ALCOHOLISM
3Gusquehanna Street
Ji Thorpe, Pa. 18229
CNTRAL WESTMORELAND COUNCIL
O ALCOHOLISM
Plsant Unity, Pa. 15676

CHESTER COUNTY COUNCIL ON
ADDICTIVE DISEASES
Committee on Alcoholism
33 E. Washington Street
West Chester, Pa. 19380

COUNCIL ON ALCOHOLISM
Welfare Council of Erie
110 West 10th Street
Erie, Pa. 16501

COUNSELING CENTER FOR
ALCOHOLISM
St. Vincent's Hospital
232 W. 25th Street
Erie, Pa. 16512

DELAWARE COUNTY COUNCIL
ON ALCOHOLISM
13 S. Avenue
Media, Pa. 19063

DIAGNOSTIC AND REHABILITATION CENTER
304 Arch Street
Philadelphia, Pa. 19106

GOOD SAMARITAN HOSPITAL ALCOHOLISM
COUNSELING CENTER
E. Norwegian and Tremont Streets
Pottsville, Pa. 17901

GREATER HAZLETON COUNCIL
ON ALCOHOLISM
Room 403, Northeastern Bank Building
Hazleton, Pa. 18201

GREENE COUNTY COUNCIL ON ALCOHOLISM
R.D. No. 3, Morningside
Waynesburg, Pa. 15370

HARRISBURG HOSPITAL—ADDICTIVE
DISEASE CLINIC
203 Market Street
Harrisburg, Pa. 17101

HILL REHABILITATION CENTER
Wylie Avenue
Pittsburgh, Pa. 15219

INSTITUTE FOR ALCOHOLISM
AND NARCOTIC ADDICTION
915 Corinthian Avenue
Philadelphia, Pa. 19130

LEHIGH COUNTY COUNCIL ON ALCOHOL ABUSE
34 N. 5th Street
Allentown, Pa. 18101

LUZERNE COUNTY COUNCIL ON ALCOHOLISM
c/o Welfare Planning Council
67 Public Square
Wilkes-Barre, Pa. 18701

MAYOR'S COMMITTEE ON HUMAN
REHABILITATION
CROSSROADS SERENITY HOUSE
331 State Street
Erie, Pa. 16507

NATIONAL COUNCIL ON ALCOHOLISM
Lancaster County, Inc.
630 Janet Avenue
Lancaster, Pa. 17601

NATIONAL COUNCIL ON ALCOHOLISM
Delaware Valley Area, Suite 1006
311 S. Juniper Street
Philadelphia, Pa. 19107

NORTHEASTERN PENNSYLVANIA COUNCIL
ON ALCOHOLISM
Room 404, Chamber of Commerce Building
Scranton, Pa. 18503

PENNSYLVANIA ASSOCIATION OF
ALCOHOLISM PROGRAMS
Box 102
Hickory, Pa. 15340

PENNSYLVANIA COUNCIL ON
ALCOHOL PROBLEMS
900 S. Arlington Avenue
Harrisburg, Pa. 17109

SCHUYLKILL COUNTY COUNCIL
ON ALCOHOLISM
111 N. Center Street
Pottsville, Pa. 17981

TRI-COUNTY COUNCIL ON
ADDICTIVE DISEASES
Room 402, Dauphin Building
203 Market Street
Harrisburg, Pa. 17101

UNITED MENTAL HEALTH SERVICES
National Council on Alcoholism
Allegheny County
4026 Jenkins Arcade
Pittsburgh, Pa. 15222

WASHINGTON COUNCIL ON ALCOHOLISM
18 Wheeling Street
Washington, Pa. 15301

WESTMORELAND HOSPITAL—ALCOHOLISM
CLINIC
Greensburg, Pa. 15601

WESTMORELAND COUNCIL ON ALCOHOLISM
P.O. Box 545
Greensburg, Pa. 15601

YORK HOSPITAL—ALCOHOLISM CLINIC
101 South George Street
York, Pa. 17405

Residential Recovery Facilities
Half-Way Houses, Shelters, Missions

ALCOHOLIC RECOVERY CENTER
(ARC HOUSE)
820 East Ohio Street, Pittsburgh, Pa. 15212
Director: Charles Cain
Phone: 412-231-5050, 231-9484

CHIT CHAT FARMS
P.O. Box 277, Wernersville, Pa. 19565
President: Richard J. Caron
Phone: 215-678-2332

COLONIAL HALFWAY HOUSE
P.O. 3204, York, Pa. 17402
Director: Arthur Becker

GREENE VALLEY FARMS
Waynesburg, Pa. 15370
President: Rev. David Else
Phone: 412-627-6530

LIVENGRIN FOUNDATION, INC.
4833 Hulmeville Road, Eddington, Pa. 19021
Administrator: Joseph Potosnak
Phone: 215-639-2300

REBOS HOUSE
5424 Second Avenue, Pittsburgh, Pa. 15217
President: W.J. Collins
Phone: 412-521-9652

SERENITY FARMS, INC.
Hickory, Pa. 15340
Director: Franklin Fagan, Jr.
Phone: 412-356-9996

ST. JOSEPH'S HOUSE OF HOSPITALITY
Tannerhill Street, Pittsburgh, Pa.
Director: Thomas O'Brien
Phone: 412-471-0666

VITAE HOUSE, INC.
R.D. No. 2, Box 500, Glenmore, Pa. 19343
President: Woolworth B. Allen
Phone: 215-942-9296

CROSS ROADS
State Street
Erie, Pa.

SERENITY HOUSE
Sixth Street
Erie, Pa.

BUTLER COUNTY REHABILITATION CENTER
Wayne Street
Butler, Pa.

Ten Commandments For Improving Survival

HARRY E. BACON, M.D., F.A.C.S.

Philadelphia

CANCER OF the colon, rectum and anal canal is now the most common visceral malignancy in the United States that affects both sexes about equally. Well known figures published by the American Cancer Society reveal that approximately 73 00 Americans had a diagnosis of colon and rectal cancer first made in 197. It causes 44,000 deaths annuly. Since the disease peaks in the late years, the increasing life expectan will tend to increase these gloomy figures unless vigorous efforts are made to reverse the trend. This can be accomplished because cancer of the colon and rectum is a potentially curable disease. But its cure requires earlier diagnosis followed by prompt and adequate surgical extirpation. This necessitates an appreciation of those avenues of spread commonly considered to be causative in recurrent disease: (1) hematogenous spread, (2) implantation, intracoelomic and intracolonic, (3) lymphatic spread and (4) direct extension.

First Commandment
Earlier Diagnosis

Earlier diagnosis is not only the first step in successfully treating these cancers but also the most important. As early as 1833 Lisfranc predicted that operative results should improve with earlier diagnosis. This observation is as pertinent today as it was then for there is no doubt that the state of the cancer is the most significant feature influencing prognosis. It is fortunate that so important a disease is so well situated that there are available relatively simple diagnostic techniques for early diagnosis. It is tragic when one considers that although 90 per cent of all rectal cancers can be diagnosed by a digital and proctosigmoidoscopic examination there are still patients who give a history of being treated for hemorrhoids. Approximately 75 per cent of all cancers of the colon, rectum and anal canal are within reach of and can be diagnosed with the 25 cm. sigmoidoscope. The remaining 25 per cent of colonic lesions can be shown by roentgenography following a barium enema. It is our feeling that the medical profession must play a pivotal role not only in direct functions of diagnosis and treatment, but in education of the public to seek earlier attention. This effort should be directed obviously toward those people with symptoms and also to those considered to be in a high risk group, but most important to the asymptomatic patient over thirty-five years of age, for it is in this later group that, hopefully, the early lesions exist and afford an opportunity for a significant improvement in the cure rate. It seems reasonable to conclude that if a cancer is detected early and treated adequately there is a greater likelihood of obtaining a "cure." We have chosen the age of thirty-five years arbitrarily but believe it to be a reasonable starting age level for screening tests.

CANCER OF COLON, RECTUM AND ANAL CANAL

September 1940—November 1970

(Bacon)

Number of Patients	2849
Number of Resected (cure or palliation)	2501
Resectability Rate	90.3%
(Curative resection - favorable & unfavorable):	83.1%
(Palliative resection - favorable & unfavorable):	16.9%
Mortality rate (70) deaths	2.7%
Five Year Survival	51.0%
Ten Year Survival	41.5%
Fifteen Year Survival	36.2% - C
Twenty Year Survival	40.9% - C

C = Corrected per age and sex

Second Commandment

Removal or Destruction of Adenomatous Polyps and Papillary Adenomata

There has been considerable controversy concerning the malignant potential of colonic and rectal polyps. It is acknowledged that although the great majority of adenomatous polyps are benign and never show malignant degeneration there are some that, left undisturbed, will progress to invasive carcinoma. We believe others are probably malignant at their onset. It may therefore be assumed that polyps are inherently dangerous and should be removed to reduce the incidence of cancer. The villous adenoma although less frequent is especially treacherous since the probability of invasive cancer was 46.6 per cent for those located in the colon, and 31.1 per cent for those situated in the rectum in our series of 261 patients. The most effective means of detection is sigmoidoscopy and roentgenography using the air-contrast barium enema technique. Both procedures require a carefully prepared bowel or some of the smaller polyps may be overlooked. If a polyp is discovered in the colon beyond reach of the sigmoidoscope it is advisable to confirm this finding with a repeat study and to search for additional polyps that may have been missed on the initial examination.

It has been our custom to remove all polyps visible through the sigmoidoscope when located below the peritoneal reflection. Low lesions frequently can be excised; the others are snared or removed with the biopsy forceps. All removed tissue is submitted for histologic study. If appropriate, the polyp may be fulgurated after a representative biopsy or two has been obtained. When necessary, based on a consideration of the pathologist's report, a formal cancer operation is performed as soon as feasible.

If the polyp is so situated that its removal requires a laparotomy we attempt to individualize the problems by balancing the potential morbidity of surgery against the probability of malignant degeneration. Previous history, size of the polyp and x-ray appearance are carefully considered. Once the decision has been made to remove the polyp this may be performed by transcolonic approach or segmental resection if the gross findings suggest a carcinoma. To perform a resection for every polyp is unwise and unrealistic. As we reported in September of last year there were 353 consecutive transcolonic polypectomies with a mortality rate of 0.6 per cent; whereas, in a series of 955 resections with end-to-end anastomosis for colonic cancer the mortality rate was 1.8 per cent. We adhere rather strictly to the following criteria. A segmental resection is performed for:

(1) A solitary adenomatous polyp that is sessile, larger than 5 mm. in diameter and clinically suspicious of malignancy.

(2) A polyp with another lesion or lesions in juxtaposition.

(3) A pedunculated polyp in which the pedicle (stalk) is short and stout, where the length of the pedicle is less than 2.5 cm. from the base of the polyp head to the bowel wall without tenting, and where the length of the pedicle is less than the diameter of the body of the polyp.

(4) A pedunculated polyp with gross characteristics of malignancy.

(5) A polyp that shows invasive carcinoma on frozen section or paraffin sections.

If only a polypectomy has been performed it is submitted for "frozen section." The operative procedure may then be extended to an adequate cancer resection if the pathologist reports invasive cancer. If this initial examination fails to show cancer but it is seen later on the permanent or paraffin sections, resection is performed seven to ten days after the colotomy and polypectomy.

In our series of patients we found the incidence of multiple polyps to be 33 per cent. In 1960 we reported on the rationale of colonoscopy for the discovery of these other polyps. The study spanned the seventeen years from 1943 to 1960 and was based on the review of 512 patients whose case histories were felt to be adequate for evaluation. It has not been our practice to carry out the procedure routinely on all patients but in this group there were 180 on whom colonoscopy was performed through the colotomy incision; although not in all instances was total colonoscopy effected through a second incision. All 512 patients had had roentgenologic identification of the polyp in two sets of preoperative studies that included the double-contrast technique. Utilizing colonoscopy, an additional polyp or polyps were seen in 61 of the 180 patients, an incidence of 33.8 per cent. This implies a roentgenologic false negative error of 33.8 per cent. The percentage of error is much higher if the x-ray study does not include the air contrast technique.

Third Commandment

Preliminary Vessel Ligation

Although cancer of the colon, rectum and anal canal spreads most frequently by way of the lymphatics, the abundant evidence now accumulated regarding the role played by loose cancer cells in the circulating blood has altered our concept in terms of metastasis and recurrence. Viable cancer cells may gain entry into the circulating blood by direct invasion of blood vessel walls, through the thoracic duct after lymphatic invasion and by "intravasation" which Cole defined as the "passage of cells from immediately adjacent normal or neoplastic tissue into vascular channels through anastomical defects in the vessel wall, occurring under certain conditions when extravascular pressure (tissue) rises momentarily above the intravascular pressure." This later mechanism is involved during the manipulation of a new growth. The early ligation of blood vessels presumably should, therefore, prevent or at least limit the spread of tumor emboli and consequently should be added to our surgical armamentarium in the performance of curative resection. All

ligations should be at a level that insures an adequate cancer resection.

Fourth Commandment

Isolation Technique of The Tumor Mass

The subject of implantation of free cancer cells constitutes an interesting and a most important study because of its relationship to recurrence and survival. Manipulation of a tumor can be expected to produce intravascular tumor emboli with resultant regional or distant metastatic foci. This same practice can also produce implants on another part of the colonic mucosa, on the peritoneal surface and also in operative wounds.

There is a decrease in the normal adhesive bond between tumor cells which results in an increased tendency to desquamate as a result of natural or manipulative forces. This shedding process is the characteristic of tumors that makes possible the early diagnosis of cancer by means of the exfoliative cytologic method as introduced by Papanicolau in 1928. These desquamated cells can, unfortunately, also be carried on the gloves and surgical instruments and thus contaminate the entire operative field. If a wash basin is in use during the operation this may serve as a reservoir for the transmission and implantation of viable cancer cells.

During the past twenty-four years, since 1946, at the suggestion of the late Raymond McNealy of Chicago, a technique has been evolved which we employ in an effort to decrease intracoelomic and intracolonic implantation. The use of various types of clamps has been discarded and we use a pad which has been moistened with 70 per cent solution of alcohol. This is tightly secured in place with umbilical tapes, the long ends of which are tied together to fashion a sling. In this manner the lesion may be manipulated as a hammock without direct contact of the growth. It is hoped that the securely tied tapes will trap any loose cells and reduce the incidence of suture line recurrence. Similarly, the pad moistened with the anticarinogen should act as a barrier against peritoneal seeding. We believe it has been effective.

Fifth Commandment

Aortoileopelvic Lymphadenectomy

Over the years we have been particularly interested in the problem of the dissemination of cancer through the lymphatics. We do not believe that lymphatic spread is the most important cause of death from cancer because evidence is available that blood-borne metastasis is more significant. The reason is that the involvement of the regional lymph nodes is probably the most common form of metastasis in cancer of the colon, rectum and anal canal and it is amenable to a surgical attack in early stages. It has been our policy to extend our efforts and perform an aortoileopelvic lymphadenectomy and aortic ligation of the inferior mesenteric artery concomitant with resection when operating for "cure" on patients with cancer of the descending colon, the sigmoid, the rectum and the anal canal. The contra-indications are: (1) elderly patients, sixty-five years or more, (2) poor risk patients who in our judgment could not tolerate well an additional hour to the procedure, and (3) extreme obesity. Obviously, it should not be performed if a "cure" cannot be anticipated, as for example, in the presence of liver metastasis.

It is difficult to assess the merit of this procedure but it is our considered opinion it has value when employed intelligently. Little has been gained for low-lying lesions in the rectum but there has been a 12 per cent increase in the five year survival for lesions of the descending colon and sigmoid.

Lymphadenectomy for cancer in other areas of the colon is performed according to the same criterion of adherence to anatomic principles.

Sixth Commandment

Wide and Extended Bowel Resection

Wide and extended bowel resection to us implies that in addition to the basic requirement of excision of the primary tumor, a lengthy segment of bowel proximal and distal to the lesion and a wide expanse of mesentery and lymph bearing tissue be removed. It is an accepted fact that distal lymphatic spread in cancer of the rectum and rectosigmoid area is limited to several centimeters but it is also known that multiple lesions exist frequently, 33 per cent in our study. Most of these additional lesions occur reasonably close to the primary growth. When situated in the rectum and lower sigmoid colon these secondary growths can be noted if a careful sigmoidoscopic examination is done. In these patients the distal cuff may be limited to generally accepted lengths. For those areas beyond the reach of the sigmoidoscope it is necessary to rely on x-ray studies to demonstrate these multiple lesions. Frequently they are missed, especially the smaller polyps, and therefore we have felt it worthwhile to remove a generous length of bowel both proximally and distally in an effort to encompass known and unknown secondary growths.

Seventh Commandment

Removal of Invaded and Suspiciously Invaded Tissues and Structures

A well conceived and properly executed operation for the cure of cancer requires that the primary tumor and all contiguous tissue that may contain tumor be removed, preferably en bloc.

Certain requirements for an adequate cancer operation for lesions of the colon, rectum or anal canal can be considered extended or ultraradical only because there is some hesitancy or trepidation in performing them routinely. Wide excision of the peritoneum is required yet is seldom performed. Generally the paracolic incisions are made hugging the bowel in order to have available a large peritoneal flap for closure. The dissection should be carried out laterally to the endopelvic fascia for removal. In most instances closures can be effected by extensive liberation of the peritoneum with finger dissection. If it is not possible to reconstruct the floor in the customary manner a large Mikulicz pack is placed deeply in the perineal wound and firmly packed with two-inch gauze. Based on experimental observations that there is excellent regeneration of peritoneum over denuded surfaces, we have employed this expedient without difficulty in over 400 patients since 1951 to extend the degree of resection, particularly when there are present small peritoneal implants in this area.

Another pitfall is encountered in making the incision in the rectouterine or rectovesical sulcus in the process of anterior mobilization. Commonly it is made in the depth of the sulcus and thereby established a cleavage plane which causes the upper part of Denovillier's aponeurosis to be left behind. The incision should be made about 2 cm. higher on the bladder or uterus so that this portion of fascia is removed since it is a common site of residual carcinoma.

Likewise, a reasonably radical operation makes it imperative that each

lateral ligament or middle hemorrhoidal pedicle be divided flat against the pelvic wall to include the lateral node-bearing areas or nodes of Cuneo and Marcille. The middle hemorrhoidal vessels do not usually require ligation.

Also, the node-beating tissue along the course of the great vessels in the pelvis and upward along the aorta and inferior vena cava should be stripped. For cancer lying at a low level in the rectum, 7 cm. or lower, radically requires a wide excision of the perianal skin and ischiorectal fat. As in any abdominoperineal procedure the levator ani must also be removed with the rectourethralis muscle. This precludes the possibility of closing the perineal wound, a procedure we are opposed to since it requires preservation of tissue which should be removed.

It is frequently observed that a cancer of the colon or rectum has become adherent to neighboring organs and with wishful optimism the thought is expressed that this represents an inflammatory reaction. Prudent surgical judgment in cancer surgery requires that all organs adherent to the primary growth be considered invaded and should be removed en bloc.

In the female patient it is our opinion that bilateral oophorectomy should be performed concomitantly with a bowel resection for colonic cancer.

Eighth Commandment

Endoscopy of Retained Segments of Bowel

Being aware of the limitations of diagnostic roentgenology, the high incidence of multiple lesions and the usefulness of operative colonoscopy during transcolonic polypectomy, it has seemed reasonable to us to extend the range of this procedure and endoscope the divided bowel ends of those patients who undergo resection and anastomosis. A sufficient number of coexisting polyps and also cancers have been discovered that we believe this is a worthwhile operative adjunct. We have not been impressed that this type of examination, carefully performed, has resulted in a higher incidence of anastomotic recurrence or peritoneal implantation.

Following discharge from the hospital it has been our routine to require all cancer patients to report for check-up every three months the first year, every six months the second and third years, and thereafter at yearly intervals. In addition to an endoscopic examination which is performed at each visit a retrograde opaque bowel study and chest x-ray is ordered bi-annually unless indicated sooner.

Ninth Commandment

Anticarcinogenic Washings

The subject of intraluminal desquamation and its relationship to suture line recurrence has been well documented.

To minimize this possibility it is our custom to follow a routine established in 1958. No enemas are given prior to operation, except for those needed to clean the bowel prior to the barium study; this is done at least several days before the operation in routine cases. Instead, mechanical cleansing is accomplished with daily doses of castor oil and on the day of surgery, two hours before operation, a colonic wash is given using 1,000 cc. of saline solution. Forty per cent eosin-alcohol is used frequently during the procedure by the operating team as a glove rinse. As an additional precaution with the open anastomosis, the transected ends of the intestinal segment are wiped with gauze sponges saturated with 40 per cent alcohol containing 0.1 per cent eosin. More recently we have been injecting the 40 per cent ethyl alcohol into the tied-off segment of the bowel.

Tenth Commandment

Radiation Therapy

The efficacy of radiation therapy in the management of cancer of the colon, rectum and anal canal is still unsettled. Radiation therapy has been used postoperatively in patients with positives nodes and in those who develop recurrence.

There is no doubt about the usefulness of radiation therapy in the palliation of certain complications. Our present concern is in the role of radiation therapy in the primary treatment of cancer in conjunction with surgery; and in this regard our interest and evaluation at the present has been in its postoperative use for selected patients. All patients who have had a resection for cancer of the sigmoid colon, rectosigmoid area, rectum or anal canal and who have positives nodes are given a 4,000 R tumor dose to the pelvis over a twenty-one day period through four portals using supervoltage radiation. If, in addition to the nodal disease, there is also liver involvement or other distant metastases, radiation therapy is not given. Instead these patients are given chemotherapy; 5 courses of 5 FU are given at six to eight week intervals. Those patients with cancer in other areas of the colon are also given 5 FU if there is nodal or distant metastasis. This is a continuing study and we have not made any final conclusions.

Dr. Bacon is professor of proctology at Temple University Health Sciences Center, St. Luke's Hospital and St. Joseph's Hospital, Philadelphia. He is a fellow of the American College of Surgeons. His paper was read before the Academy of Surgery, University of Krakow, Poland, in May of 1970.

Summary

This discussion stems from a personal series of 2;849 patients with cancer of the colon, rectum and anal canal covering a period between September 1940 and November 1970.

There were seventy deaths, an operative mortality rate of 2.7 per cent. The five, ten, fifteen and twenty-year survival has been calculated as 51 per cent, 41.5 per cent, 36.2 per cent, 40.9 per cent; the last corrected for age and sex.

At the time of this writing the author had performed 309 consecutive abdominal or abdominoperineal resections on private patients for major pathologic entities without a single postoperative death; but such is not the result of any superior surgical maneuver or ability, but rather because of a dedicated team of round-the-clock workers, a team of devoted and interested surgical residents, and consultants, including the anesthesiologists, the internists, the radiologists, biochemists, pathologists, and an expert superiorly trained nursing staff. Individualization of each patient by a dedicated team has proved most rewarding. □

Environmental Causes of Fetal Malformations

FRED B. NUGENT, M.D.

Reading

ALL MEN are not born equal despite the guarantees of the United States Constitution. These inequalities are not based on race, creed or color. Instead they are the result of the genetic constitution inherited from their ancestors.

The discovery and elucidation of the DNA-RNA—ribosomal mechanisms—permits the understanding of the fusion of maternal and paternal elements in the chromosomes. This fusion results in the formation of a template, which in turn determines the genetic constitution of the embryo. These chance combinations, over which the fetus has no control, will determine in large measure whether he or she will have a happy life with the expectation of good health or a troubled existence handicapped by inborn errors of metabolism or physical deformity.

In the study of fetal malformations it soon became apparent that all these abnormalities could not be explained on a strictly hereditary basis. The study of environmental causes of fetal malformations received tremendous impetus through two major events in medical history: First, the discovery by Gregg of Australia in 1941 that serious fetal malformations occurred in the children of mothers who had suffered attacks of Rubella in the first trimester of gestation. Secondly, the 1961 report by Lenz of Germany that an appalling train of malformation followed the administration of thalidomide to pregnant women.

It is not the purpose of this presentation to review the clinical syndromes which result from environmental causes of fetal malformations. These have already been well documented. Its purpose is: to examine some of the more recent discoveries in embryogenesis, to list the known environmental causes of abnormal fetal development, and to explore the mechanisms by which each agent affects the developing fetus.

Realizing the necessity of mobilizing the best minds in basic science and clinical medicine to meet these problems, a series of international conferences on congenital malformations has been organized. The source material in this discussion is derived largely, but not entirely, from a perusal of the reports emanating from these conferences.

A review of the clinical syndromes produced by all causes of fetal maldevelopment emphasizes four basic facts.

1. The *time* of the insult determines the type of defect. Cells in active proliferation have a low resistance to teratogenic agents.

2. The *type* of injury is important and may result in damage either to the genetic mechanism or the basic elements of cell physiology.

3. The *severity* of the insult determines the result. It may vary from minor damage to complete destruction.

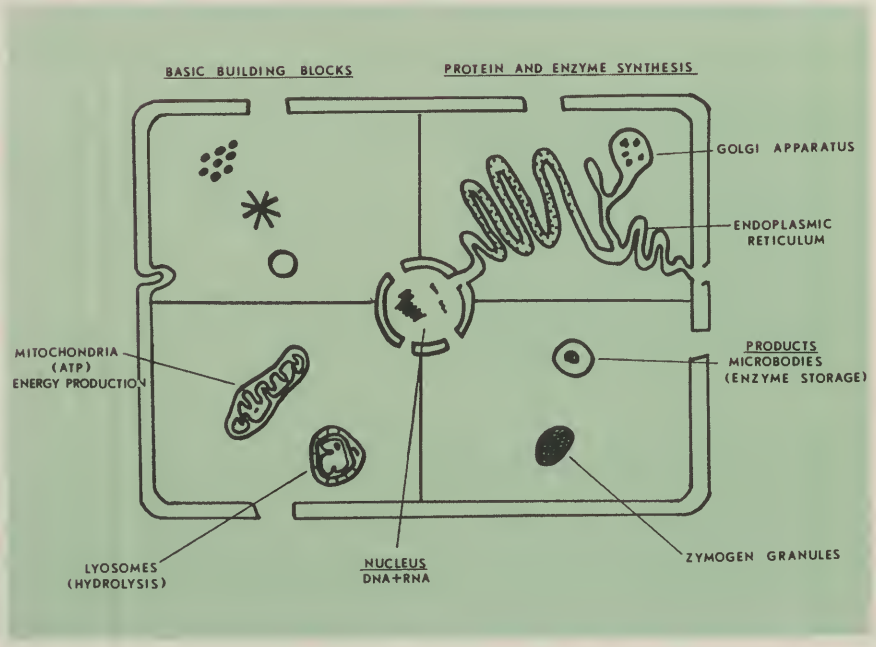
4. The *spacial relations* at the time of the injury are significant. Developing tissues in contact with each other exert mechanical, biochemical, and either inhibiting or stimulating influence on the neighboring structures. In this manner a defect in one tissue induces a defect in its neighbor.

Much has been learned about the induction of anomalous development by animal experimentation. Fraser[1] has emphasized the pitfalls in attempting to extrapolate experimental teratogenesis in animals to man, to other species of animals, or even the same species with a different hereditary strain.

The tragedies which followed the use of thalidomide could have been avoided if its testing for teratogenicity had followed this rule.

Epigenetic Crisis

An "epigenetic crisis" as defined by Waddington[2] is a period in develop-



ment when the fetus is most susceptible to teratogenesis. These crises occur at three developmental stages: during oogenesis, in late blastula and early gastrula formation, and whenever the anlage of a major organ or system is being laid down. The common denominator of each of these critical periods is intense intracellular metabolic activity requiring the incorporation of large amounts of new material brought in from outside the cell. Deleterious agents are also introduced into the cellular metabolism with these new materials, frequently at a time when the cell's defensive endoplasmic reticulum is not present. Waddington has also called attention to changes in lipid and carbohydrate metabolism within the individual cell about which we know very little.

Since environmental agents which do not destroy the entire embryo exert their deleterious effects on anatomical or physiologic processes within the cell in a specific manner, a brief review of cellular anatomy and physiology is in order.

Cellular Physiology

Within the nuclear membrane lie the clumped chromatin bodies containing the DNA, double stranded helix, which controls all other cellular metabolism. So far as is now known it never leaves the nucleus but exerts its influence on the cytoplasm through RNA, a single stranded messenger, which passes through the fenestrated nuclear membrane into the cytoplasm of the cell.

The *cytoplasm* serves as a reservoir of basic building blocks, amino acids, lipids and carbohydrates. Within the cytoplasm lie the *organelles*,[3] vital ultramicroscopic structures essential to the metabolic processes within the cell. The *mitochondria* are the sources of energy production through the activity of adenosine triphosphate (ATP). Of equal importance is the *endoplasmic reticulum*, a tubular lipo-protein membrane. It is divided into two distinct parts. First, the *rough endoplasmic reticulum* which is the site of the ribosomes which synthesize the proteins and enzymes dictated through the medium of the messenger RNA. It acts as a cell stabilizer in that its enzymes not only control vital processes within the cell, but also aid in the detoxification and metabolism of drugs and other noxious agents deleterious to embryologic development. Secondly, the *smooth endoplasmic reticulum* which communicates through porous openings in the cell membrane with the surrounding substrate - bringing in replacements of the basic building blocks to cells in active proliferation and allowing the passage of the products it manufactures into the intracellular fluid for transmission to other sites. Lying in close relationship to it is the *Golgi apparatus*, the function of which is to gather together and package the proteins and enzymes manufactured by the ribosomes for storage and for transmission to the fetal circulation. Two other important structures have been identified in the cytoplasm: the *microbodies*, which consist of stored enzymes and the *lyosomes*, which are considered the center of hydrolysis. The fenestrated cell membrane itself is composed of three layers: an outer layer of protein, a middle layer of lipids, and an inner layer of protein.

The unfertilized egg cell differs in certain important aspects from all other cells. It has only half the normal chromosomal material. It has no demonstrable endoplasmic reticulum, and its ribosomes are inactivated supposedly by a protein covering.

During oogenesis genes on the chromosomes engage in most intense activity and an enormous amount of material is stored in the cytoplasm of the egg.[4] Immediately following fertilization there is an intense production of proteases in the egg cytoplasm which are thought to dissolve the protective coating and activate the ribosomes which are already present.[5] It is further established that the development of the embryo, at least until early gastrulation, is entirely under the control of maternal genes stored in the egg cytoplasm. The *nuclear gene-action* system does not become operative until gastrulation has been established. Protein and other enzymatic development is carried on from the building blocks stored in the cytoplasm. Since up to this stage no new materials are brought in from the outside, the egg is resistant to environmental teratogenic agents. However, in early gastrulation the gene-action system in the embryo begins to function and the protection against teratogenesis is lost. The susceptibility of the individual cell is further heightened by the absence of a developed endoplasmic reticulum which acts as a cell stabilizer.[6] In this relatively short period of development the cell is most easily injured by environmental deleterious substances.

By late gastrulation the endoplasmic reticulum has been laid down, functions, and increases the defense mechanisms of the individual cell through enzyme production.

Harris[7] states that enzyme formation is genetically controlled by two types of genes. First, the structural genes which dictate the amino acid sequence in the polypeptide chain. Secondly, the regulatory genes which stimulate or inhibit the formation of the enzymes. Any environmental interference with these control mechanisms disturbs both the metabolism and the organogenesis of the fetus. An alteration in the polypeptide sequence can entirely destroy the effectiveness of the enzyme in the developmental or detoxifying activity which it is designed to catalyze.

With gastrulation the cells acquire two very important capabilities. For the first time they adhere forming channels through which the nutrient substrate can circulate. In addition, they acquire the ability to pump fluids in a polarized fashion into the various spaces characteristic of the developing embryo. Any environmental agent which interferes with these capabilities results in major fetal anomalies.

With this brief and necessarily incomplete review, let us now consider the known environmental causes of fetal malformation and examine the scientific evidence indicating the mode of action of each.

ENVIRONMENTAL TERATOGENIC FACTORS

1. *X-radiation.*
2. *Viral diseases and related infections.*
3. *Chemical factors.*
4. *Immunologic disturbances.*
5. *Hormones.*
6. *Nutritional factors.*

Ionizing Radiation

Ionizing radiation is mentioned chiefly for completeness. It is the oldest of the known teratogenic agents. It has been established that its genetic

influence results from interference with DNA synthesis and replication causing a nonspecific fragmentation of the nuclear material of cells in active proliferation with abnormal karyotypes.

VIRAL DISEASES ASSOCIATED WITH FETAL MALFORMATIONS

1. *Rubella.*
2. *Mumps.*
3. *Varicella.*
4. *Herpes zoster.*
5. *Measles.*
6. *Infectious hepatitis.*
7. *Virus pneumonia.*
8. *Infectious mononucleosis.*
9. *Cytomegalic gland virus.*
10. *Vaccinia.*
11. *Influenza.*

Katz[8] describes what happens in a cell invaded by a virus as follows: In two to six hours after invasion of the cell by a virus, hundreds of new virions consisting of a nucleus of DNA in a thin protein capsule are formed. Four types of host cell response develop depending on the type of virus under study:

1. *Replicative lytic* characterized by cell destruction with liberation of the new viruses.

2. *Replicative nonlytic* in which the cells live, divide and pass virus to daughter cells.

3. *Non-replicative proliferative* in which cell reproduction is accelerated indefinitely without detectable evidence of residual virus. This type of response shows the continuation of virus-specified new elements in the cell influencing genetic information.

4. *Replicative proliferative* accompanied by a stimulatory effect on the host cell which proliferates in a reliable fashion leading to the formation of typical lesions prior to cell death.

For the purpose of this study only two viral infections will be considered: Rubella and Cytomegalic (salivary gland) Virus.

Katz has classified Rubella in the replicative non-lytic group. Cooper[9] reports that at the cellular level Rubella inhibits mitosis and increases the number of chromosomal breaks in cultures of human embryonic cells. In fetal tissue cultures obtained at therapeutic abortion, only a small number of the cultured cells are infected. Ratios of 1 to 100,000 up to 1 to 250,000 cells show evidence of viral invasion. Infected daughter cells grow slowly and organs from infected infants show a subnormal number of cells. Moorhead[10] emphasizes that whereas x-ray produces random breakage in all areas of chromosomes, certain viruses and chemicals induce breakage more frequently at the centromeres or other areas of constriction.

Jacobson[11] calls attention to the fact that virally induced or post-radiation abortion may be due to preconceptional damage to the oogonia rather than post-conceptional effects on the fetus.

Nowell[12] states that there is a great disparity between chromosomal damage and resultant somatic damage in animals.

Cytomegalic Inclusion Disease

Hanshaw[13] recommends that cytomegalic inclusion disease be considered as potentially dangerous to the fetus as is Rubella. Following cellular invasion with this agent individual cells become markedly enlarged—hence the name. The essential pathological process is one of cell destruction. It is thus classified as a replicative lytic virus.

Toxoplasmosis

This disease is caused by a protozoal parasite which invades the infant during intrauterine life or shortly after birth. It occurs only during the active stage of infection in the mother and not in the encysted or inactive form of maternal disease. Its mechanism is cell destruction by invasion by the active parasite.[14]

Chemical Agents

All the known chemical teratogens act by blocking enzymes. Age is an important determinant of microsomal drug metabolizing enzyme activity. Until the endoplasmic reticulum, which manufactures enzymes, is laid down, drug metabolism and detoxification is limited. Fetal defense against deleterious chemicals is further enhanced in later development when fetal hepatic enzymes become available to detoxify them.[15]

The first four agents listed influence glucose metabolism. *Thalidomide* blocks the enzymes which liberate glucose during organogenesis.[16] It may also affect the metabolism of glutamic acid, glutamine, and riboflavin.

Quinine and its derivatives block the action of six phosphofructokinase necessary to the conversion of glucose to lactate.

The action of *tolbutamide (Orinase®, Upjohn; Diabinase® (Pfizer), and insulin* needs no amplification. The significance of these three drugs in teratogenesis is questionable.

DRUGS INFLUENCING DNA-RNA SYNTHESIS

(A.) ANTIMETABOLITES
(Folic Acid Analogues)

1. *Methotrexate and Aminopterine.*
2. *Pyrimidine Analogues—Fluorouracil.*
3. *Purine Analogues—6 Mercaptopurine.*

The antimetabolite agents inhibit the biosynthesis *de novo* of purines in ribonucleotide formation through thymadilate kinase blocking. They also prevent the conversion of adenine and guanine precursors in the formation of RNA.[15]

DRUGS INFLUENCING DNA-RNA SYNTHESIS
(B.) ALKYLATING AGENTS

1. *Nitrogen Mustards—Leukeran, Alkeran.*
2. *Ethylenimine Derivatives—Tepa, Thiotepa, Triethylenemelamine.*
3. *Methyl-Sulfonates—Amethopterin.*
4. *Cyclophosphamides—Cytoxan.*

These alkylating agents are radiomi-

KNOWN CHEMICAL TERATOGENS

1. *Thalidomide.*
2. *Quinine & Derivatives.*
3. *Tolbutamide & Diabinase.*
4. *Insulin.*
5. *Antimetabolites.*
6. *Alkylating Agents.*
7. *Corticosteriods.*
8. *Lysergic Acid Diethylamide.*

metic drugs which inhibit the synthesis of DNA and, to a less extent, RNA. They are active thymadilate kinase blockers.[17]

The best studied antibiotic is Actinomycin D which suppresses induction of enzymes involved in the synthesis of messenger RNA.[17] It has no effect on DNA synthesis.

DRUGS INFLUENCING RNA SYNTHESIS

(C.) ANTIBIOTICS

1. *Actinomycin D.*
2. *Streptonigrin.*
3. *Mitomycin C.*

The best studied of corticosteroids is triamcinolone. Zimmerman[18] reports that it principally inhibits RNA synthesis, but also slows protein synthesis to a less extent.

Lastly, LSD has come under intense scrutiny. Jacobson examined six fetuses, obtained at therapeutic abortion, whose mothers had been on LSD. Each showed an exencephalic central nervous system lesion. While Jacobson[19] felt that abortion after virus infection, radiation or chemicals may be due to preconceptional effects on the oogonium, mothers who had formerly taken LSD but stopped during pregnancy showed no more chromosomal breakage than a control series and no congenital anomalies were encountered.

Cohen[20] states that LSD actually suppresses mitosis and that there is a definite dose-response relationship. It is a powerful esterase inhibitor.

Immunologic Disturbances

Best known to all of us are the Rh and ABO incompatibilities which need no elaboration. Other immunological responses are normal and physiologic but can have deleterious effects.

Fetal blood contains antibodies of two types: Gamma M7's derived from the mother and Gamma M and G manufactured by the fetus. Theoretically these should provide as much protection in the fetus as the adult enjoys. There are two exceptions caused by deficient complement in the fetus and resultant immunologic incompetence.

At a surprisingly young age the fetus can respond to some antigens but not to others. As gestation progresses to a certain critical age, different for each antigen, the fetus can and does respond with antibodies, hypersensitivity and all that this implies. Two well known examples illustrate the deleterious effects of competence. In lymphocytic choreomeningitis, invasion by the virus in the incompetent mouse leads to viremia but no demonstrable deleterious effect. However, when the animal acquires competence, the disease produces extensive lesions resulting in death.

Similarly, treponemata can be demonstrated in the fetus afflicted with congenital syphilis but no lesions appear until after the fifth month of gestation when the fetus has acquired competence to respond.[21]

The rare athyrotic cretinism is known to be caused by circulating antithyroid antibodies in the maternal blood.[22]

In the laboratory simulated accidents of immune mechanism may be demonstrated by injecting experimental animals with antisera from the eye, the heart, the kidney and the brain. Langman,[23] using the chick embryo as his experimental subject, used an antiserum derived from the alpha crystallin fraction of lens protein. In high dilutions there were no demonstrable effects. In intermediate dilutions, however, degenerative changes were produced not only in the eye but also in the brain.

Masculinizing Hormones

Jones and Scott[24] have written extensively on iatrogenic deformities of the female genitalia produced by the administration of exogenous testosterone, synthetic progestogens, and related preparations to pregnant women. The causal relations of these agents have received wide publicity in medical circles. These defects are again becoming a rarity except where congenital hyperplasia of the adrenal exists in the fetus or where the mother herself has a coexisting arrhenoblastoma during gestation. These agents work by suppression of the influence of the female hormone on developmental mechanisms.

Dr. Nugent, a retired general practitioner, serves as a volunteer with the Economic Opportunities Council of Reading and Berks County health clinic in Reading. Prior to his retirement he was director of the department of obstetrics and gynecology at the Reading Hospital.

Cortisone, ACTH, and Related Corticosteroids

Despite the frequency of cleft palate in the experimental animal treated with these substances, only occasional deformities of the closure of the palate have been reported when these substances are employed in therapeutic doses in treatment of the mother.

Nutritional Defects

In the experimental animal it has been possible to induce major malformations by severe limitations of nutritional elements in the diet.

In humans—despite wars, poverty and ignorance—no such anomalies have been experienced.

Endemic cretinism results from low iodine content in the maternal diet. Low I.Q.'s in infants born to mothers with low serum protein levels have been reported. This variation in maternal protein metabolism is not related to low protein diet, but is due to some unexplained idiopathic defect in her blood levels.

Summary and Discussion

The purpose of this discussion has been threefold: First, to present some recent advances in embryology; secondly, to list the known environmental causes of fetal malformations; and third, where possible, to explain the precise effect each has on the mechanisms of fetal development.

The prevention of congenital anomalies of strictly hereditary type eludes us. However, the obstetrician has a real opportunity to eliminate fetal malformations due to environmental causes.

He will serve his patient best who:

1. Avoids radiation in early gestation unless the severity of the patient's illness warrants taking the risk.

2. Helps his patient to avoid viral infections by preconceptional immunization and the avoidance of exposure to known or potentially infected friends.

3. Screens carefully all medication given to the pregnant woman including hormones.

4. Selects the proper time in her life cycle for all immunological procedures. ☐

(List of references provided on request)

CALORIES / 7 oz. Serving*

Beef Broth	22	Vegetable	68
Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

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Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

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6-12 mo. . . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . . 1 tsp. 5 times daily (10 mg.)
Adults: . . . . 2 tsp. 5 times daily (20 mg.)
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*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age.

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Acute Pulmonary Embolism Masquerading As Myocardial Infarction

MARTIN N. FRANK, M.D.

and

ARTHUR LINTGEN, M.D.

Abington

THERE HAVE been many excellent publications[1,2,3,4,5,6] describing the clinical profile of pulmonary embolic disease. The elusive nature of this disorder has been well documented.[2]

With the advent of radio-isotape of the lung[7,8] the clinician has a relatively simple diagnostic means of diagnosing this entity. It has been common clinical experience that the "classic" electrocardiographic S1, Q3, with staircase ascent of the ST segment in lead II pattern of McGinn and White,[9] or characteristic x-ray changes are present in less than 30 per cent of patients with pulmonary embolism. Several authors have published clinical "triads" present with lung infarction. Tench described the triad of tachycardia, digitalis toxicity, and mercurial-fast edema in congestive heart failure complicated by pulmonary embolism.[10] Wacker et al.[11] have published a series of cases of pulmonary embolism, with or without lung infarction, characterized by an elevated LDH, moderate elevation of the serum bilirubin, and normal SGOT values.

Figure 1, Case 1: A and B, left to right: *The radioisotope lung scan shows a diminished perfusion of the left lower lobe. Repeat lung scan two weeks later shows improved perfusion in this area.*

It would be superfluous to add another paper describing the complete

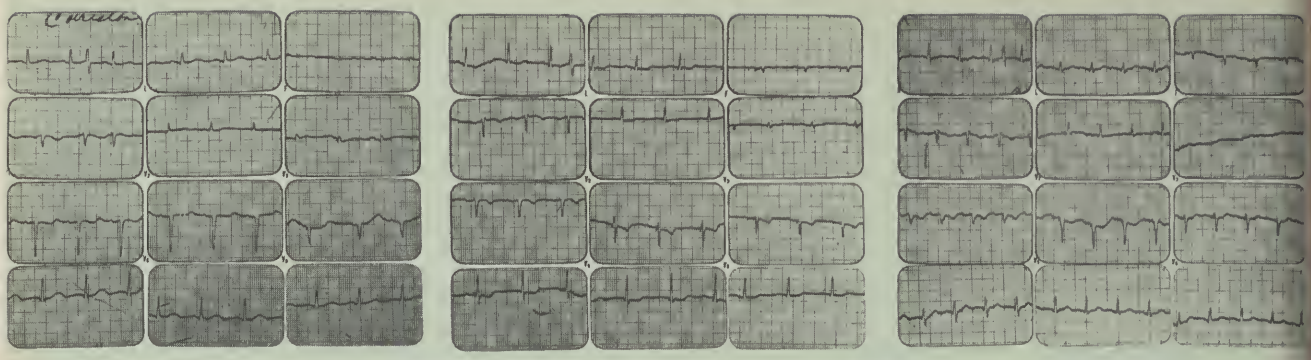

Figure 2, Case 1: A, B and C. left to right: *The EKG of 5-20-68 shows a previous transmural anteroseptal infarction. The tracing of 7-12-68 reveals inverted T waves in the area of the previous infarction. By 7-20-68 there has been substantial resolution of the T wave inversions which represented acute right heart overload.*

clinical syndrome of pulmonary embolism. We recently had five patients, in a three month period, with acute pulmonary embolism who were initially suspected of having a myocardial infarction because of their clinical or electrocardiographic findings. All patients were characterized by lack of ST segment elevation or failure to develop Q waves on the electrocardiogram (EKG) and had no rise in the serum LDH, SGOT, hydroxy butyric dehydrogenase (HBD) or bilirubin levels.

We suspect that many patients with acute pulmonary embolism are erroneously diagnosed as having had an acute myocardial infraction. Because of the important differences in treatment and prognosis between these two disorders, we are reporting the clinical features present in two representative patients.

Case Reports

Case 1: E.C. is a 76 year old white female admitted to the hospital on July 9, 1968 two months after having had transmural anteroseptal myocardial infarction complicated by recurrent ventricular tachyrhythmias. She now presented with recurrent sharp left precordial pain radiating posteriorly, aggravated by respiration, and accompanied by dyspnea.

Physical examination revealed an elderly white female with pallor and mild dyspnea. Temperature was 97.2 degrees, pulse 84, respirations 24, and blood pressure 160/80. There was a regular sinus rhythm with a Grade III systolic ejection murmur. There was tenderness to palpation over the left anterior chest wall. Homans', Moses',* and Lowenberg's** sign were negative.[12,13]

Chest x-ray revealed cardiomegaly and clear lungs. There was decreased uptake over the lower half of the left lung field on a lung scan performed on July 10, 1968 (Figure 1). A repeat scan on July 29, 1968 (Figure 1) revealed an increase in uptake in this area. Initial and serial LDH, SHBD, SGOT, and bilirubin values were all normal.

The initial EKG of July 8, 1968 was read as an acute anteroseptal infarction (Figure 2). Subsequent EKG's showed less anterior T wave inversion (Figure 2) with residual evidence of the old anteroseptal infarction. An EKG, taken at the time of her previous hospitalization, on May 20, 1968 showed an anteroseptal infarction (Figure 2). The patient was given heparin, and despite several episodes of recurrent chest pain aggravated by respiration, she became symptom free eventually. The patient was discharged on Coumadin® (Endo) therapy.

Case 2: A.J. is a 44 year old white female admitted on August 11, 1968 with a diagnosis of angina pectoris which had been previously diagnosed at other institutions. The patient had noted progressive chest pain until the night of admission when she developed severe chest pain radiating to the neck and chin, lasting one hour and unrelieved by nitroglycerin.

On admission, temperature was 98 degrees, pulse 88, respirations 20 and blood pressure 160/98. The heart was in normal sinus rhythm with no audible gallop sound. The neck veins were flat and the lungs were clear. Mild left parasternal chest wall tenderness was present, and Lowenberg's sign was positive on the left leg. Homans' and Moses' sign were negative.

Chest x-ray on August 12, 1968 was normal. The EKG on August 11, 1968 revealed T wave inversion in V-3 which resolved by August 13, 1968. No other changes occurred in the serial tracings.

Lung scan on August 13, 1968 showed an irregular decrease in activity through the medial aspect of the left lower lung field (Figure 3). Repeat scan on September 23, 1968 showed normal distribution of radioactivity (Figure 3). On August 11, 1968, the SGOT was 10, HBD 137, LDH 20, and bilirubin 0.4 mg. per cent. Serial enzyme determinations were within normal limits.

Discussion

It would have been virtually impossible to substantiate the diagnoses of acute pulmonary embolism in these two patients without the use of radioisotope lung scanning. All patients had an initial abnormal lung scan, and in follow-up lung scans considerable improvement in the radiosotope uptake occurred. Certain clinical features were present however, which although not diagnosis of acute pulmonary embolism. These features included (1) type of pain, (2) chest wall tenderness, (3) the presence of an atrial gallop sound, and (4) the electro-

** Moses sign: Tenderness on firm pressure of the fingers applied directly to the posterior calf when there is no significant tenderness on firm compression of the calf from side to side.*
*** Lowenberg's sign: The appearance of pain over the calf on slowly distending a sphygmomanometer cuff to 200 mgs. Hg. over 10-15 secs. A positive test is pain at 60-150 mgs. Hg.*

cardiographic findings. One patient had signs of active phlebitis.

1. The incidence of anginal type pain in acute pulmonary embolism has been reported to vary between 25 and 37 per cent.[3,4] Pleuritic type of chest pain has occurred in 15 to 67 per cent of patients.[2,3,4,6] One of our patients had anginal type pain at the time of admission, and the other had pleuritic pain. It is well known that anginal pain may occur with pulmonary embolism.[1,2,3,4,6,14] According to Gorham[1] pain identical with myocardial infraction occurs when larger pulmonary vessels are occluded. Acute myocardial infarction was erroneously diagnosed in twenty of his 100 necropsied cases, and nineteen of his cases had pain similar to that of acute myocardial infarction.[1] It has been well documented that anginal pain may occur in the presence of a normal coronary arterial system.[1,13,16] There have been numerous theories to explain this type of pain. Scherf[15] postulated a "pulmonocoronary" reflex with coronary spasm resulting from the acute pulmonary embolism. There is considerable doubt as to whether this exists.[17] Megibow et al.[18] suggested pulmonary hypertension increasing the intramural pressure of the right ventricle with compression of the Thebesian veins interfering with emptying of the coronary veins. The right atrial hypertension would also hinder coronary sinus outflow. Sodi-Pallares group showed immediate "inversion of ventricular pressures" after pulmonary infarction in dogs which developed right ventricular hypertension, and left ventricular hypotension.[20] This would, of course, decrease the perfusion pressure of the coronary vessels. There may be respiratory acidosis with depression of myocardial function.[18] Anaerobic myocardial metabolism consequent to hypoxia could impair myocardial blood flow.[20] Other factors such as right heart failure with decreased venous return to the heart,[21] and increased pulmonary arteriovenous bronchopulmonary anastomotic flow,[22,23] would impair left heart function. Any associated coronary artery narrowing would compound the left heart ischemia. Pulmonary artery distention itself might cause pain.[1]

2. Chest wall tenderness has been described in 18 per cent of Israel and Goldstein's series[2] and in 73 per cent of Dexter et al.'s patients.[3] Chest wall tenderness was not associated with pleuritic pain in two of our three patients who manifested this sign. The tenderness is probably due to irritation of the parietal pleura, and it is difficult to understand why it is not accompanied by pleuritic type of pain. However, we regard local chest tenderness as a valuable clinical sign suggesting pulmonary embolism.

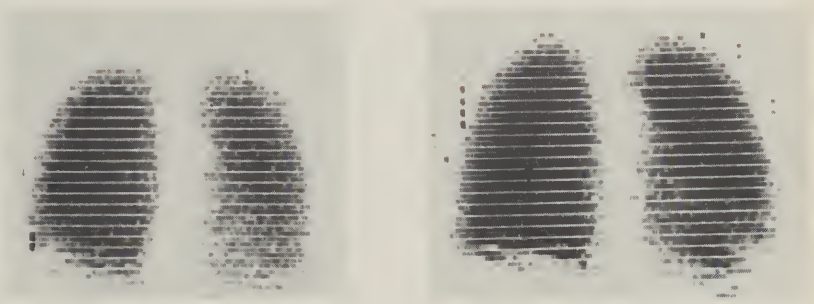

Figure 3, Case 2: A and B, left to right: *The lung scan of 8-13-68 shows significantly decreased uptake in the left lower lung field which improved by 9-23-68.*

3. The two patients with an atrial gallop sound had no significant change in intensity of the sound with respiration. The presence of an atrial gallop sound which increases with inspiration would be a clue of right overload if present. It is likely that left atrial gallop sounds could occur due to some of the adverse factors affecting left heart dynamics. The presence of underlying coronary disease would aggravate this abnormality.[24]

4. The most significant electrocardiographic finding in our series was inversion of the right precordial T wave in four of the five patients. In each instance, the EKG was initially read as a non-transmural anterior infarction. Other abnormalities such as axis shift, the classic McGinn-White pattern,[9] and P wave abnormalities were not meaningful in this group. In part, this was because this particular group of patients was selected as presenting a possible acute non-transmural myocardial infarction. The pattern of right precordial T wave inversion has been previously described.[18,24,25] Israel and Goldstein[2] reported its occurrence in 13 per cent of their cases. This pattern could result from relative coronary insufficiency or right heart overload. Zuckermann et al.[16] termed this pattern right ventricular ischemia, and demonstrated electrophysiologic abnormalities involving the right ventricular wall, right septal surface, or both. They ascribed associated left precordial T wave inversion to the decrease gradient of coronary flow; a pattern demonstrated in humans by Dack.[26] Many other electrocardiographic findings in addition to the classic McGinn-White pattern, have been described by other authors.[2,25,26]

None of our patients had an elevated LDH level. This is difficult to reconcile with the statement of Wacker[11] and Amador,[27] that this enzyme is invariably elevated in acute pulmonary embolism with or without infarction. Six of the seventeen patients in Wacker's series came to autopsy. Fortunately, we have no autopsy material so that our patients evidently had less extensive pulmonary embolic disease than Wacker's patients. Radioisotope lung scanning was not available at the time of Wacker's study. Serum bilirubin was elevated in eleven of fifteen of Wacker's cases so that his patients probably had more extensive lung embolization. Coodley[28] found an increase of LDH in ten of seventeen patients and a rise in SGOT in four of seventeen patients with pulmonary infarction. Certainly, the LDH enzyme determination is a significant clinical laboratory test. The specificity of the serum LDH in acute pulmonary embolism requires further clarification.

This small group of patients differs from larger series in the absence of hemoptysis and positive x-ray findings. Also evidence of shock, arrhythmias, and elevation of LDH and bilirubin levels were absent. It is likely that the selection of this series by positive lung scanning presents a less severely involved group of patients than those reported in large series, many of which were documented by necropsy studies. We relied heavily on lung scanning, but did not perform any pulmonary

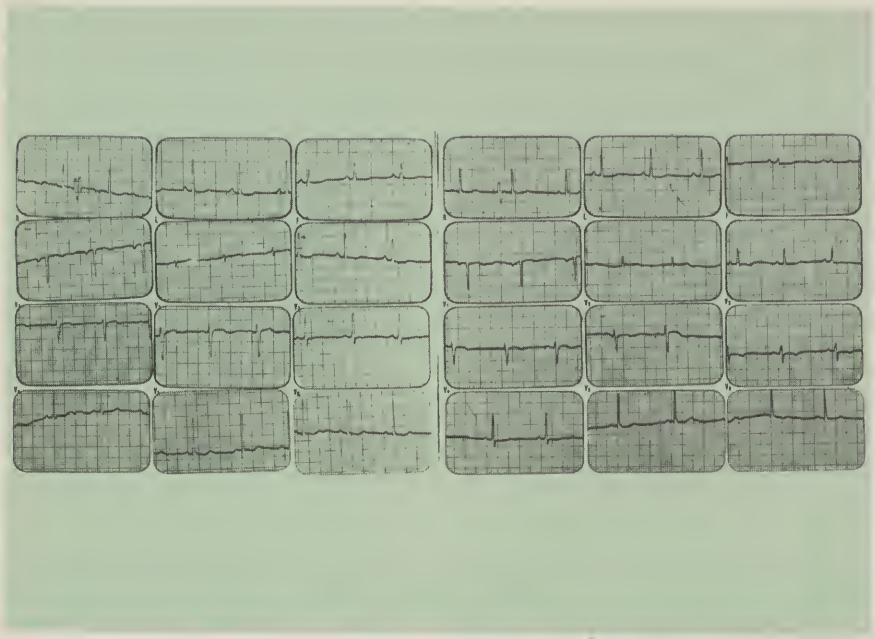

Figure 4. Case 2: A and B, left to right: *Right precordial T wave inversions are noted on the EKG of 8-11-68. Two days later the T waves are less.*

angiograms in these patients. The assumption was that a subsequent, improved lung scan validated the initial diagnosis of pulmonary embolism. Several patients, in whom we suspected pulmonary embolism, had diffuse bilateral impairment in lung radioisotope uptake, and were not included in this series. Pulmonary vascular congestion without embolization can give this pattern. All of our patients had discrete abnormalities in uptake which appeared to be typical of localized lack of lung perfusion, and which significantly improved in the five patients in whom lung scans were obtained.

Summary

Five patients with acute pulmonary embolism were originally suspected of having an acute non-transmural myocardial infarction because of initial clinical or electrocardiographic findings.

Chest wall tenderness was present in three patients and an atrial gallop sound was heard in two of the subjects. Serum enxymes and bilirubin were not elevated. Four of the five patients had right precordial T wave inversion on the EKG. An initial abnormal lung scan, with subsequent improvement, occurred in all patients.

Conclusions

1. The diagnosis of pulmonary embolism should be suspected in all patients who present as a non-transmural infarction.

2. Chest pain identical with that of coronary insufficiency may occur with pulmonary embolism.

3. The use of serial radioisotope lung scans is a valuable diagnostic tool in suspected pulmonary embolism.

Acknowledgment

We wish to thank Dr. E. Tulsky of the nuclear medicine department who interpreted the lung scans. Dr. J. Roderick Kitchell kindly reviewed the manuscript. □

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Surgery In Operable Breast Cancer

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At the present level of our knowledge, the best treatment for Stage breast cancer is surgery. This implies treatment before the inexorable geometric progression of the tumor causes spread beyond the limits of local resectability. Early diagnosis, which must be defined as diagnosis prior to the development of metastasis, is the one presently available factor controlling prognosis. Once metastasis has occurred, even to the accessible axillary lymph nodes, then there is likelihood that other undetectable tumor foci may have settled elsewhere; to grow, to spread, and eventually to kill. A high rate of long-term and tumor-free survival is thus dependent on locally treatable disease. There is no such thing as carcinoma in the breast which will remain local indefinitely.

The most effective method for the early diagnosis of a breast tumor remains in the hands of the patient. She must have an awareness of her own particular breast patterns, and she must promptly report real or suspected changes to her physician. A mass as small as one centimeter should be noticed by the patient. Because of the different rates of growth and the tendency of some small tumors to spread early, this method remains imperfect even with the complete cooperation of the patient. Attempts to discover growths before they are large enough to be palpable are continuing. Mammography and thermography have been successful in some situations, but they have not as yet been practicable as screening devices on a large scale.

Has Stood Test of Time

Standard radical mastectomy, which includes removal of the pectoral muscles and axillary contents, has stood well the test of time in the treatment of breast adenocarcinoma. The en-bloc resection principles in cancer surgery as first put forth by Halsted and Meyer in the 1880's are as true today as they were then. Actually the operative technique since then has undergone no major modifications. Changes have aimed at better cosmesis and less morbidity. The use of a transverse incision as advocated by Stewart allows effective exposure in most instances with no evidence of the incision even when an off-the-shoulder dress is worn. The practice of leaving some of the clavicular head of the pectoralis major softens the depression which occurs in that area. One way morbidity is lessened is by the use of newer plastic drains which serve to siphon off fluid accumulation during the early postoperative period. Another is early resumption of arm movement postoperatively, to lessen the tendency toward shoulder and arm stiffness and fixation.

Technique Important

The technique of radical mastectomy deserves some mention. After the patient is prepared in the operating room, an incisional biopsy is taken for immediate frozen section examination. When the diagnosis of carcinoma is substantiated, great care is taken to avoid the seeding of malignant cells in the operative field. An alcohol-soaked gauze sponge is placed in the biopsy wound and oversewn with a continuous strangulating suture. The operative site is again prepared with alcohol solution after the biopsy instruments, surgeons' gloves, and gowns have been discarded. An alcohol-soaked gauze is then placed over the closed biopsy incision and sutured into place.

The mastectomy incision is next made, in a transverse fashion when practicable. There should always be at least a three-centimeter margin between the mastectomy incision and the biopsy site. The flaps are next raised by sharp dissection in the subcutaneous fat. Suitably thin flaps should be used to ensure adequate removal of all breast tissue, but not so thin as to jeopardize blood supply. It is our feeling that recurrence at the line of in-

cision has usually been due not to the presence of tumor cells in skin lymphatics, but to the seeding of tumor cells in the wound at the time of incisional biopsy. The flaps should be raised cephalically to the clavicular portion of the pectoralis major muscle, caudally to the rectus sheath, medially to the sternum and laterally to the latissimus dorsi muscle. After hemostasis is secured, incision into the pectoralis major is made parallel to and about two centimeters below its clavicular attachment, and this incision is extended down to the clavicopectoral fascia. The insertion of this portion of the pectoralis muscle is transected at the humeral head and the muscle retracted. The pectoralis minor muscle is next severed in its tendinous attachment and is also retracted caudally. This exposes the axillary vein and the highest point of the axilla, medial to the pectoralis minor. The fatty lymph node-containing tissue is then swept downward via sharp dissection from medial to lateral, sparing the long thoracic and thoracodorsal nerves. When axillary dissection is complete, the breast is then removed by sharp dissection, beginning at the sternal attachments and proceeding laterally to the latissimus dorsi. The weight of the specimen is a natural aid in supplying countertraction during this part of the operation. The skin is closed after hemostasis is secure and any loose tissue washed from the wound with saline lavage. Plastic suction tubing is used to drain accumulated fluid in the postoperative period. The morbidity of this type of surgery is minimal and the operative mortality extremely low.

Problems in Simple Mastectomy

Simple mastectomy, with or without postoperative irradiation, has been advocated as satisfactory treatment of carcinoma of the breast. Simple mastectomy combined with postoperative irradiation seems more radical than a radical mastectomy because of the extent of lung exposure to x-rays with resulting fibrosis. Simple mastectomy alone leaves disease behind in approximately one-half of patients who are operated upon, for approximately 50 per cent have histologic evidence of nodal involvement when radical mastectomy is performed. Crile has recently advocated simple mastectomy initially with later axillary dissection, if lymph node enlargement occurs. It is his belief that there is a beneficial immunity afforded by these nodes, and if involvement is evident later, one still has the opportunity to remove the diseased nodes. This argument does have a logical theorectical basis and may later prove valid. At present, his disciples are few.

It is our feeling that simple mastectomy is a satisfactory operation in carefully selected patients. One example is when lobular carcinoma in situ is diagnosed. As in this instance, when invasion has not occurred then lymph node involvement should not occur. Certainly, in cystosarcoma phyllodes which very rarely metastasize to regional lymph nodes, a simple mastectomy is adequate.[1] In most other situations in which simple mastectomy may be useful, it is only in retrospect that one is sure that a radical was not necessary. Tumor size alone is no guarantee that lymph node metastasis has not occurred. It has been distressing to discover axillary metastasis when a tumor too small to palpate has been found by mammography. Some patients with cancers as small as three millimeters have had histologic evidence of lymph node involvement. In Paget's disease without a palpable mass, as many as 14 per cent (in one series) had lymph node involvement — simple mastectomy would have left removable disease behind.[2] When one uses a simple mastectomy to treat breast cancer of any type, he should be aware of the possibility that cancer may be left behind in the axillary nodes. A simple mastectomy is probably as good as a radical when there is a two and a half centimeter or larger carcinoma located in a medial segment of the breast. In this situation metastasis to the internal mammary chain of nodes is likely and postoperative irradiation advisable. The supraradical mastectomy has been designed to include these nodes in the dissection. Few surgeons have adopted this procedure since the morbidity is significantly higher, and the cure rate not significantly better than when irradiation is added to the usual operation.

Adjuvant chemotherapy is still in the process of being evaluated as far as long-term survival is concerned. There has been some evidence to show that concommitant use of thiotepa, an alkylating agent, increases the rate of survival at two years in one group of patients. They are the premenopausal women with positive axillary nodes. This is preliminary data and should be considered as such. It is not general practice to combine surgery and chemotherapy at present.

Rehabilitation Important

A very important aspect of complete adequate postoperative care which has received too little emphasis in the past is rehabilitation. The mastectomee must be prepared to return to her preoperative life upon discharge from the hospital. This means not only physically, but also emotionally and socially. In addition to the usual post-operative exercises to help retain and restore shoulder-arm motion, it has proved helpful to have a volunteer, who has herself undergone a mastectomy, visit the patient in the early postoperative period. This woman-to-woman approach provides benefits that can be achieved in no other way. The volunteer can help demonstrate how it is possible to return to a normal, productive life after mastectomy. These women are available in many areas through the Reach to Recovery Program of the American Cancer Society.

Cancer of the breast is highly curable if diagnosed early. Careful technique provides a reasonable cosmetic effect and total rehabilitation of the mastectomy patient should be anticipated. □

Drs. Rosemond and Maier are with the department of surgery at Temple University Health Sciences Center. Dr. Rosemond, who is professor there, is president-elect of the Pennsylvania Medical Society.

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Treatment of Breast Cancer

Articles on alternative methods in the management of breast cancer which have appeared in recent issues of women's magazines and in the *Wall Street Journal* have prompted a number of inquiries.

This problem has been discussed at medical meetings for more than twenty years and, at present, most physicians still prefer mastectomy as the treatment of choice and do so in good faith. Many cured mastectomy patients and women who are soon to undergo breast surgery have called the offices of the American Cancer Society expressing their anxiety about what they have read.

During the last Annual Meeting, this matter was discussed by the American Cancer Society's medical advisory committees and the resulting policy statement was approved:

Policy Statement

"The value of mastectomy (removal of the breast) in the treatment of breast cancer has been challenged in recent publications.

"The large gains in the saving of lives in breast cancer have been achieved by the use of this operation often supplemented by radiation therapy and other treatment.

"Pending clear proof that equally good results can be achieved by doing less, the American Cancer Society believes that the American public should not be stampeded into accepting less proven methods.

"Although data is being continuously gathered and evaluated, there is as yet no clear and convincing evidence that equivalent results can be achieved.

"Breast cancer occurs in different pathological and clinical forms. These call for different types of treatment.

"For these reasons it is essential that patients facing this problem discuss any questions they may have with their physician."

(See Operable Breast Cancer on Page 75)

ANCER FORUM — presented cooperatively by the PMS Council on Education and Science. The Pennsylvania and Philadelphia visions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum edited by Roland A. Loeb, M.D., Lancaster.

Arteriovenous Fistula

Meyer Naide, M.D. and David Naide, M.D., Division of Vascular Diseases, Graduate Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania, are questioned by William G. Leaman, Jr., M.D.

What causes an A-V fistula or abnormal arteriovenous communication or arteriovenous aneurysm?

There are two types: The first is the congenital type which results from persistence of embryologic communications between artery and vein. The second type is the so-called traumatic or acquired type caused by a penetrating wound, such as from a knife, gunshot or flying projectile or as a complication of intervertebral disc surgery. Rarely, rupture of an abnormal aortic aneurysm into the inferior vena cava can be a cause. The popliteal and femoral vessels are the most common sites of A-V fistula.

What are the characteristics of the congenital type?

Signs and symptoms usually begin in childhood or infancy. They are most common in the extremities, although they can occur anywhere, including renal or pulmonary areas. The communications are usually multiple. In the extremities, varicosities commonly result because of the increased venous pressure from the direct communication with the arterial system. Therefore, if a patient presents early in life with unilateral varicose veins, especially if in an unusual location, with enlargement of the limb, one must think of an A-V fistula.

What are some of the other clinical signs of congenital A-V fistula?

One may encounter increased sweating, increased hair growth, increased limb growth, or increased skin temperature. There may or may not be a thrill and/or bruit, depending on how large the A-V communication is. The venous blood becomes arterialized proximal to the A-V fistula as far as oxygen saturation. Arteriograms are not always easy to interpret.

How Should congenital A-V fistula be treated?

If the communications are few and close together, they can be closed surgically, but this is not often the case with the congenital type, where the communications are usually multiple and small. Elastic support of the leg may be helpful.

What other findings are helpful in the diagnosis of A-V fistula?

Increased venous O_2 proximal to the fistula compared to the uninvolved side is the most helpful finding in confirming the diagnosis. Direct pressure over the site of the A-V fistula may abolish the bruit and/or thrill. The so-called Branham's sign of bradycardia and increased blood pressure on digital compression of the fistula is only useful with large arteriovenous connections bordering on cardiac failure. There may be increased venous pressure, decreased circulation time, increased cardiac output and increased blood volume. Although not often helpful in congenital arteriovenous fistulas, arteriography may help to localize an acquired A-V communication and aid in outlining the extent of collateral circulation.

Is there any problem with arterial insufficiency with arteriovenous fistula?

Initially, there may be a slightly decreased peripheral arterial flow, but this usually returns to normal or may even become increased. Very rarely, distal gangrene can develop in the early stages.

How common is cardiac enlargement and/or failure?

Actually, this is not common unless the communication is large and of long duration. The heart enlargement, when it occurs, is chiefly cardiac dilatation (because of increased velocity of blood flow and increased venous pressure), rather than cardiac hypertrophy. When present, the dilated heart can return to normal size within one month after surgical correction of the abnormal arteriovenous communication.

How should traumatic arteriovenous fistulas be managed?

Although they occasionally close spontaneously, it is best to operate on most lesions of this type and surgically obliterate the fistula about three to six months after the injury. If there is external hemorrhage with distal arterial insufficiency, immediate operation, of course, is necessary. Excision of the aneurysm with arterial reconstruction is the preferred method of treatment.

William G. Leaman, Jr., M.D. edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.

INTERMITTENT COURSES

Listed below are courses of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, contact the director at the address given in the course listing.

GASTROENTEROLOGY

Philadelphia; January 14—April 18, 1971
I/AMA—SYSTEMATIC REVIEW OF GASTROENTEROLOGY; by U. of Pa.; at Lecture Room A; 4 hrs. ea. day; 1 day ea. week; 8 weeks; 32 hrs. AAGP credit requested; $150 fee. Contact Aaron D. Freedman, M.D., Assoc. Dean, U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

GENERAL MEDICINE

Aliquippa-Rochester Hosps. (rotation); third Wed., ea. mo.
Altoona Hospital; fourth Thurs. ea. mo.
Greensburg (Westmoreland Hosp.); first Tues. ea. mo.
Johnstown (Conemaugh Valley Mem. Hosp.); first Thurs., ea. mo.
Natrona Heights (Allegheny Valley Hosp.); second Tues. ea. mo.
Uniontown Hospital; last Mon. ea. mo.
Washington Hospital; first Wed. ea. mo.

O/I—DIAGNOSIS AND MANAGEMENT OF HYPERTENSION; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin P. Shapiro, M.D., Project Dir., 501 Flannery Bldg., 3530 Forbes Ave., Pittsburgh 15213.

Allentown; September 2, 1970—May 5, 1971
I—TEAM APPROACH TO PATIENT CARE (Fall-Winter Education Program); at Sacred Heart Hosp.; first Wed. ea. mo.; 3 hrs. each day; AAGP credit applied for. Contact Vincent J. Jerant, M.D., Chm. House Staff & Educ., Sacred Heart Hosp., 4th & Chew Sts., Allentown 18103.

Altoona Hospital; October 15, 1970—May 20, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every other Thurs.; 7 months; 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 17, 1970—May 20, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Luke's Hosp.; third Thurs. ea. mo. (except December); 8 mos.; AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford/Kane; October 20, 1970—May 18, 1971

CODE KEY

C—Consecutive days
I—Intermittent
O—Circuit
PG—Postgraduate Traineeship
S—Designed for full-time specialists
AMA—AMA Accredited Institution
CES—Council on Education and Science, Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
Hershey—Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Pitt—University of Pittsburgh, School of Medicine
Pitt P.H.—University of Pittsburgh, Graduate School of Public Health
Penn State—Pennsylvania State University
Temple—Temple University Health Sciences Center
U. of Pa.—University of Pennsylvania, School of Medicine
Woman's—The Medical College of Philadelphia

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; alternately at Bradford's Penn Hills Club and Kane Manor; third Tues. ea. mo.; 18 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Chester; September 8, 1970—May 25, 1971
I/AMA—POSTGRADUATE SEMINARS FOR PHYSICIANS; by Hahnemann; at Crozer-Chester Med. Center; 2 hrs. AAGP credit approved ea. day; 38 days; a day ea. week. Contact James E. Clark, M.D., Chief of Med., Crozer-Chester Med. Center, 15th & Upland Sts., Upland, Chester 19013.

DuBois Hospital; February 4—April 8, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Thurs.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

East Stroudsburg; October 17, 1970—April 17, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at General Hosp. of Monroe Co., third Sat. ea. mo., (except December); 18 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Erie; September 17-18, 1970—May 13-14, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Vincent's Hosp.; Thurs. eve. and Fri. morn.; approx. once every three weeks; 39 hrs. AAGP credit applied for. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Gettysburg; January 12—April 21, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at Annie Warner Hosp.; alternating Tues. and Wed. every other week; 24 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Hazelton State Gen. Hosp.; September 2, 1970—May 26, 1971
I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hazelton Branch of Luzerne Co. Med. Soc., and Hosp.; 1½ hrs. per day; 1 day per week; 36 weeks; 30 hrs. AAGP credit. Contact Robert L. Gunderson, M.D., Dir. of Med. Educ., Hazelton State Gen. Hosp., Hazleton, Pa. 18201.

Johnstown; November 24, 1970—May 25, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Conemaugh Valley Memorial Hosp., fourth Tues. ea. mo. (except Jan.); 6 sessions, 2 hrs. ea.; 12 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lancaster General Hosp.; September 22, 1970—May 18, 1971
I—CONTINUING MEDICAL EDUCATION PROGRAM; 1 day ea. week; 18 weeks; 3 hrs. AAGP credit applied for ea. session. Contact John H. Esbenshade, Jr., M.D., Dir. of Medical Educ., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17601.

Lancaster Gen. Hosp.; January 14—February 25, 1971
I—TECHNIQUES OF CURRENT THERAPY; by the Institute of Pa. Hosp., Depts. of Med. Educ. and Family & Community Med. (Lancaster Gen. Hosp.), Lancaster Chapt. of A.C.P., and Citizens Ad. Council on Drug Abuse; 1½ hrs. ea. day; 1 day ea. week; 6 weeks; 9 hrs. AAGP credit requested; $20 fee. Contact N. J. Zervanos, M.D., Dir., Dept. of Family & Community Med., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17602.

Lancaster Osteopathic Hosp.; October 8, 1970—March 11, 1971
I/AMA—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; 16 Thursdays; 2 hrs. ea. day; Contact Harold F. White, D.O., Chmn., Prg. Comm., Lancaster Hosp., 1100 E. Orange St., Lancaster 17602.

Lebanon; November 3, 1970—May 4, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Quentin Riding Academy; first Tues. every other month; AAGP credit requested. Contact John Killough, Ph.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lewistown Hospital; February 10—April 14, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Wed., ea. mo.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Lock Haven Hospital; October 21, 1970—May 5, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Meadville; September 2, 1970—May 5, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first Wed. ea. mo. at Spencer Hospital; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Philadelphia; September 14, 1970—May 17, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Methodist Hosp.; first and third Mon. ea. mo. (except holidays); AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Pottsville; September 24, 1970—May 27, 1971
I/AMA—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; at Good Samaritan Hosp.; fourth Thurs. ea. mo. (except Nov., Dec. and Apr.); 2 hrs. ea. day. Contact Norman M. Wall, M.D., Dir. of Med. Educ., Good Samaritan Hosp., E. Norwegian and Tremont Sts., Pottsville, 17901.

Pottsville Hospital; September 3, 1970—June 3, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; first Thurs. ea. mo.; 10 mos.; 2 hrs. AAGP credit approved per session. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

Reading; September 22, 1970—May 25, 1971
I—1970-71 CONTINUING EDUCATION PROGRAM; at St. Joseph's Hosp.; fourth Tues. ea. mo. (except December); 8 hrs. AAGP credit requested. Contact Kenneth M. Schreck, M.D., Med. Dir., St. Joseph's Hosp., 215 Walnut St., Reading 19603.

Sayre; August 24, 1970—June 14, 1971
I—ROTATING SEMINARS (10 sessions Cardiology; 5 sessions Dermatology; 11 sessions Endocrinology; 13 sessions Hematology; 7 sessions Neurology; 8 sessions Psychiatry; 4 sessions Radiation Therapy; 9 sessions Urology—Nephrology); at Robert Packer Hosp.; 1 hr. ea. session; hour-for-hour AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., Dir. Med. Educ., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Scranton; October 21, 1970—May 19, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Mercy Hosp.; 1 day a month; 8 months; 24 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Sellersville; September 23, 1970—June 16, 1971
I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann and Grandview Hosp.; at Grandview Hosp.; fourth Wed. ea. mo. (except December); 18 hrs. AAGP credit requested. Contact D. Henry Ruth, M.D., Dir. of Med. Educ., Grandview Hosp., Sellersville 18960.

Sharon General Hospital; October 21, 1970—April 7, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Somerset Community Hospital; October 14, 1970—May 12, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; second Wed. ea. mo. except Jan. & Feb.; 18 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

St. Marys; October 25, 1970—February 28, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program) by Educational and Scientific Trust of PMS; at St. Marys Country Club; fourth Sunday ea. mo. (except December); 12 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Tunkhannock; March 17—May 19, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program) by Educational and Scientific Trust of PMS; at Tyler Memorial Hospital; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Uniontown Hospital; October 14, 1970—March 24, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every other Wed., (except December); 30 AAGP credit applied for. $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wellsboro; March 17—May 19, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Soldiers & Sailors Hosp.; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wilkes-Barre General Hospital; September 17, 1970—April 15, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; third Thurs. ea. mo.; 8 mos.; 3 hrs. AAGP credit approved for ea. session. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Williamsport Hosp.; September 11, 1970—March 12, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; second Fri. ea. mo. (except January); AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

INTERNAL MEDICINE

York Hospital; September 17, 1970—April 29, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every Thurs.; 30 weeks; 3 hrs. AAGP credit approved ea. day; $40 fee ($8.00 single session). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Philadelphia; October 14, 1970—May 12, 1971
I/AMA—INTERNAL MEDICINE REVIEWS; by Hahnemann; at Alumni Hall; 3 hrs. a day; 1 day a week; 27 weeks; $150 fee ($70 per subspecialty); 81 hrs. AAGP credit approved. Contact Wilbur A. Oaks, M.D., Prog. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

MALIGNANT DISEASE

Philadelphia; September 9, 1970—June 23, 1971
I—CANCER DETECTION IN OFFICE PRACTICE; at American Oncologic Hosp.; 4 hrs. a day; 1 day a wk.; 20 hrs. AAGP credit approved; course repeated every 5 weeks. Contact Joseph G. Strawitz, M.D., Assoc. Dir., American Oncologic Hosp., Central & Shelmire Aves., Philadelphia 19111.

MICROBIOLOGY & IMMUNOLOGY

Allentown Hosp.; September 10, 1970—June 10, 1971
I—IMMUNOLOGY: BASIC CONCEPTS-CLINICAL APPLICATIONS (A Program of Continuing Medical Education; by Jefferson and Penn State; second Thurs. ea. mo.; 10 mos., 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc., Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

Danville; September 16, 1970—May 19, 1971
I—PSYCHIATRY AND COMMUNITY MENTAL HEALTH; by The Institute of Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. ea. day; 1 day a wk.; 10 weeks; 20 hrs. AAGP credit applied for. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Danville; September 24, 1970—May 27, 1971
I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. per day; 1 day a week; 20 weeks; 40 hrs. AAGP credit applied for $25 fee.

Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster Gen. Hosp.; February—April, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; 2 hrs. ea. day, 1 day ea. week; 20 weeks ea. semester; 40 hrs. AAGP credit applied for; $25 fee ea. semester. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Norristown State Hospital; March 5, 1971—May 21, 1971

I/S—FAMILY THERAPY; by Norristown State Hospital; 2 hrs. each day; one day each week; 10 weeks; $50 fee. Contact John D. Pruitt, M.D., Dir. Cont. Educ. for Psychiatrists, Norristown State Hospital, Stanbridge and Sterigere Sts., Norristown 19401.

Norristown; March—May, 1971

I—THE LATENCY AGE CHILD: by The Institute of the Pennsylvania Hosp.; at Montgomery Co. Mental Health Clinics, Inc.; 2 hr. a day; 1 day a week; 8 weeks; 16 hrs. AAGP credit applied for; $50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 8, 1970—April 6, 1971

I—MEDICAL HYPNOSIS; by the Institute of the Pennsylvania Hosp. and U. of Pa., Div. of Grad. Med.; at The Institute; 4 hrs. a day; 1 day a week; 20 weeks; 80 hrs. AAGP credit applied for; $150 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 14, 1970—March 3, 1971

I/AMA—PSYCHIATRIC PROBLEMS OF CHILDREN; at Hahnemann; every Wed. (except holidays); 18 weeks; 36 hrs. AAGP credit requested; $75 fee. Contact Paul J. Fink, M.D., Dir. of Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 21, 1970—June 2, 1971

I/AMA—SEMINARS IN PSYCHOTHERAPY; SHORT-TERM, CRISIS AND SUPPORTIVE THERAPIES; at Hahnemann; three 10-week seminars; every Wed.; 20 hrs. ea. seminar; AAGP credit requested; $75 fee for 10-week session, $150 for 30 sessions. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; January 7—March 25, 1971

I—TECHNIQUES OF CURRENT THERAPY IN THE MANAGEMENT OF MARITAL PROBLEMS, ADOLESCENT PROBLEMS AND CHRONIC COMPLAINERS; The Institute of Penna. Hosp.; 3 hrs. a day; 1 day a week; 12 weeks; 36 hrs. AAGP credit applied for; $50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; February 23—March 30, 1971

I/TREATING TODAY'S ADOLESCENT; by Institute of Pa. Hosp. of U. of Pa.; at The Institute; 1½ hrs. a day; 1 day per week; 6 weeks. Fee $50. Contact J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; February 23—April 27, 1971

I/TREATING SEXUAL INCOMPATIBILITY; by Institute of Pa. Hosp. and U. of Pa.; at Marriage Council of Philadelphia; 2½ hrs. a day; 1 day per week; 10 weeks. Fee $50. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; February 22—March 29, 1971

I/PSYCHOPHARMACOLOGY; by Institute of Pa. Hosp. and Dept. of Psych. of U. of Pa.; at 111 N. 49th St.; 2 hrs. a day; 1 day a week; 6 weeks. Fee $50. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; April 7—May 12, 1971

I/AMA—DRUGS: PSYCHOTROPIC, PSYCHEDELIC AND ADDICTING; at Hahnemann; every Wed.; 6 weeks; 12 hrs. AAGP credit requested; $50 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; March 24—May 26, 1971

I/AMA—ADOLESCENCE AND THE YOUTH CULTURE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 10 hrs. AAGP credit requested; $75 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CONTINUOUS COURSES

Sessions of the following courses will convene continuously until completed.

ANESTHESIOLOGY

May 27—29, 1971; Pittsburgh

C/LIFE SUPPORT-MAJOR ORGAN SYSTEM FAILURES (Fifth Annual Symposium on Acute Medicine) by Amer. Soc. of Anesthesiologists; at Pittsburgh Hilton; $100 fee. Contact Bulent Kirimli, M.D., c/o Dept. of Anesthes., V.A. Hosp., Pittsburgh 15240.

CARDIOVASCULAR DISEASE

February 24—26, 1971; Philadelphia

C/AMA—CURRENT CONCEPTS IN THE THERAPY OF CORONARY ARTERY DISEASE; at U. of Pa.; 8 hrs. ea. day; 24 hrs. AAGP credit requested; $100 fee. Contact Aaron D. Freedman, M.D., Assoc. Dean, U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

March 18—19, 1971; Philadelphia

C/AMA—HYPERLIPIDEMIA AND ATHEROSCLEROSIS; by U. of Pa.; at University Museum; 14 hrs. AAGP credit requested; $75 fee. Contact Office of Grad. Med. Educ, U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

May 6—7, 1971; Pittsburgh

C—EXPLORING SURGICAL TREATMENT FOR MYOCARDIAL INFARCTION; by Pa. Heart Assoc. (21st Annual Scientific Sessions); at Chatham Center; $25 fee (medical students, residents and interns free); $5 additional for ea. luncheon. Deadline for advance registration: April 22. Contact Pa. Heart Assoc., P.O.Box 2435, Harrisburg 17105.

CHEST DISEASES

March 1-12, 1971; Philadelphia

PG—POSTGRADUATE COURSES IN BRONCHOESOPHAGOLOGY; at Temple, Contact Charles M. Norris, M.D., Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

March 17, 1971; Reading Hospital

C—ENVIRONMENTAL LUNG DISEASE; by Pa. Chapt. Amer. Coll. of Chest Physicians and Reading Hosp. Contact Mrs. Joan Hamilton, Reading Hosp., Reading 19602.

April 28—30, 1971; Philadelphia

C/AMA—RESPIRATORY INTENSIVE CARE UNIT; by U. of Pa.; at Annenberg Auditorium (on campus); 7 hrs. ea. day; 21 hrs. AAGP credit requested; $125 fee. Contact Office of Grad. Med. Educ., 288 Med. Labs. Bldg., Philadelphia 19104.

ENDOCRINOLOGY

March 10, 1971; Sharon

C/AMA—MEDICAL AND SURGICAL ASPECTS OF THYROID DISEASE: by Jefferson and Penn State; 3 hrs. AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

FORENSIC MEDICINE

March 1971; Berks Co. Med. Soc., Reading
April 14, 1971; William Penn Hotel, Pittsburgh
May 1971; Conemaugh Valley Mem. Hosp., Johnstown
June 1971; Lehigh Valley Club, Allentown

O—MALPRACTICE IN THE EMERGENCY ROOM; by CES; 3 hrs. AAGP credit $5 fee. Contact Comm. on Emerg. Med. Serv., Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pa. 17043.

GENERAL MEDICINE

March 12, 1971; Hershey Medical Center

C—SELECTED TOPICS FOR EMERGENCY ROOM CARE; by Pa. Committee on Trauma of Amer. Coll. of Surgeons and Pa. Nurses' Assoc.; AAGP credit requested; registration limited to 150; $7.50 fee (includes luncheon), payable to Pa. Committee on Trauma, A.C.S. Contact W. E. DeMuth, M.D., Chrm., 17 S. West St., Carlisle 17013.

April 3, 1971; Harrisburg

C—DIABETES; by CES and Pa. Osteopathic Assoc.; at Holiday Inn Town; 6 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

INTERNAL MEDICINE

March 1—5, 1971; Philadelphia

C/AMA—PULMONARY PHYSIOLOGY; by U. of Pa.; at Hospital of U. of Pa.; 8 hrs. a day; 40 hrs. AAGP credit requested; $150 fee. Contact Office of Grad. Med. Educ., U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

March 22—23, 1971; Philadelphia

C/AMA—SMALL BOWEL; by U. of Pa.; at Grad. Hosp. of U. of Pa.; 14 hrs. AAGP credit requested; $75 fee. Contact Office of

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May 19-21, 1971; Philadelphia
C/AMA—PATHOPHYSIOLOGY OF PULMONARY DISEASE; by U. of Pa.; at Annenberg Center of Communications; 7 hrs. ea. day; 21 hrs. AAGP credit requested; $125 fee. Contact Office of Grad. Med. Educ., U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

MALIGNANT DISEASE

February 10, 1971; Allentown
C—ORAL CANCER SEMINAR; by Amer. Cancer Soc., Pa. Div., Inc.; at Lehigh Country Club; for physicians, dentists, nurses and technicians; 6 hrs. AAGP credit requested. Contact W. Richard Covert. D.D.S., P.O. Box 4175, Harrisburg 17111.

NEUROLOGY

May 26-28, 1971; Philadelphia
C/AMA—NEWER ASPECTS OF NEUROLOGY AND NEUROSURGERY; by U. of Pa.; at Hospital of U. of Pa., 7 hrs. ea. day; 21 hrs. AAGP credit requested; $100 fee. Contact Office of Grad. Med. Educ., 288 Med. Labs. Bldg., Philadelphia 19104.

OBSTETRICS & GYNECOLOGY

April 15, 1971; Hershey Motor Lodge
C—12TH ANNUAL MATERNAL & CHILD HEALTH INSTITUTE; by CES and Pa. Dept. of Health; $10 fee; 4 hrs. AAGP credit applied for. Contact Comm. on Maternal & Child Health, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

OPHTHALMOLOGY

April 28-30, 1971; Pittsburgh
C/S—OPHTHALMOLOGIC MICRO-SURGERY; by Pitt; at Eye and Ear Hospital; 24 hrs.; $400 fee. 20 limit. Contact Kenneth T. Richardson, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

May 5-7, 1971; Pittsburgh
C/S—STRABISMUS (A Comprehensive Symposium in Diagnosis and Treatment); by Pitt; at Eye and Ear Hospital; 24 hrs.; $200 fee; 20 limit. Contact David A. Hiles, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

OTOLARYNGOLOGY

April 1-2, 1971; Philadelphia
C/AMA—THERAPY IN OTOLARYNGOLOGY; 1971 (Postgraduate symposium); by Jefferson; $50 fee ($10 to residents). includes luncheon both days and one dinner. Contact William Baltzell, M.D., Dept. of Otol., Jefferson, 1025 Walnut St., Philadelphia 19107.

April 26—May 7, 1971; Philadelphia
C/AMA—PRACTICAL COURSE IN BRONCHO-ESOPHAGOLOGY; by U. of Pa.; at Grad. Hosp. of U. of Pa., 7 hrs. ea. day; 70 hrs. AAGP credit requested; $250 fee. Contact Office of Grad. Med. Educ., U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

OTORHINOLARYNGOLOGY

February 14—20, 1971; Pittsburgh
C/S—ANATOMY AND SURGERY OF THE NOSE; by Eye and Ear Hosp., Pittsburgh Otological Society, Pa. Acad. of Ophthalmology and Otolaryngology, and Pitt.; at Pitt. and Eye and Ear Hosp., 8 hrs. per day, 7 days; $500 fee. Contact Kenneth H. Hinderer, M.D., Clin. Assoc. Prof. of Otolaryn., Pitt., 400 Medical Arts Bldg., Pittsburgh 15213.

PEDIATRICS

March 29—April 2, 1971; Philadelphia
C/AMA—A FIVE-DAY REFRESHER COURSE FOR PEDIATRICIANS AND GENERAL PRACTITIONERS; by U. of Pa.; at Children's Hosp.; 27 hrs. AAGP credit approved; $185 fee. Contact F.B. Becker, M.D., Chrm., Post Grad. Educ. Committee, 1740 Bainbridge St., Philadelphia 19146.

May 5—7, 1971; Philadelphia
C/AMA—BRONCHIAL AND ESOPHAGEAL DISEASE IN INFANCY AND CHILDHOOD; by U. of Pa.; at Grad. Hosp. U. of Pa.; 21 hrs. AAGP credit requested; $75 fee. Contact Office of Grad. Med. Educ., U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

PUBLIC HEALTH & PREVENTIVE MEDICINE

June 23, 1971; University Park
C—SPORTS MEDICINE CONFERENCE; by CES and Penn State. Contact CES, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.

SURGERY

March 29—April 2, 1971; Philadelphia
C/AMA—MAXILLOFACIAL ANATOMY AND SURGERY; by U. of Pa.; 7 hrs. ea. day; 35 hrs. AAGP credit requested; $175 fee ($100-anatomy only; $100-surgery only). Contact Office of Grad. Med. Educ., U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

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obituaries

○ *Indicates membership in the Pennsylvania Medical Society at time of death.*

○ **Henry G. Bregenser**, Pittsburgh; University of Pittsburgh School of Medicine, 1931; age 64; died October 4, 1970. He is survived by his wife and a son.

○ **Ross K. Chiderhose**, Harrisburg; Queens University, 1921; age 72; died October 8, 1970. Until 1962 he had served as head of service and chairman of the department of chronic pulmonary disease at Harrisburg Hospital. In 1968 he was made emeritus professor of medicine of Hahnemann Medical College. Survivors include his wife and a daughter.

○ **Walter H. Wishard**, Waynesboro; Jefferson Medical College, 1917; age 76; died October 11, 1970. Dr. Wishard served in the Army Medical Corps during World War I. He had served as president of the Waynesboro Hospital medical staff and as chief of the medical department. His wife and two daughters survive.

○ **George B. Davis**, Waynesboro; College of Physicians and Surgeons at Baltimore, 1908; age 89; died October 21, 1970. Surviving are his wife, two daughters and a son.

○ **Catherine D. Edgett**, Lewisburg; Medical College of Pennsylvania, 1929; age 78; died October 17, 1970. Before her retirement she served as head physician at the Connecticut State School and Hospital, and was an active member of the American Association of Mental Deficiency. She is survived by a number of cousins.

○ **Benjamin Greenspan**, Elkins Park; University of Pennsylvania School of Medicine, 1938; age 59; died October 5, 1970. He had served as a surgeon at Albert Einstein Medical Center for twenty years. His wife survives.

○ **Jesse E. Packer**, Newtown; University of Pennsylvania School of Medicine, 1916; age 79; died October 12, 1970. Before his retirement last year he had practiced medicine in Newtown for more than fifty years. He was a member and past president of the Bucks County Medical Society. Two daughters survive.

○ **Edward A. Parker, Jr.**, Philadelphia; Temple University School of Medicine, 1912; age 84; died October 6, 1970. Dr. Parker, a former chief surgeon at Roxborough Memorial Hospital, had received the PMS Fifty Year Award. Surviving are his wife, a son, Edward A. Parker III, M.D., and a sister.

○ **Edward A. Schumann**, Lafayette Hill; University of Pennsylvania School of Medicine, 1901; age 91; died October 18, 1970. He was a charter member of the American Board of Obstetrics and Gynecology. Surviving are his wife and three sons, one of whom is Francis Schumann, M.D.

○ **Eugene B. Schuster**, Pittsburgh; Rush Medical College of the University of Chicago, 1933; age 67; died October 3, 1970. Dr. Schuster was a pediatrician and a lecturer on the growth and development at the University of Pittsburgh. His wife, a son and a daughter survive.

○ **Hugh C. Stevenson III**, Waymart; Hahnemann Medical College and Hospital, 1920; age 76; died September 24, 1970. A physician of Waymart for more than fifty years. Dr. Stevenson had served as a past president of the Wayne-Pike Medical Society. Survivors include his wife, a son and a daughter.

○ **Gerard P. Hammill**, Pittsburgh; University of Maryland School of Medicine, 1935; age 62; died October 21, 1970. Dr. Hammill had long been a key figure in county public health facilities and care of the aged and indigent, and had served as head of the John J. Kane Hospital since 1958. He also worked for the establishment of a foster home placement program for Pennsylvania. Survivors include his wife, a son and two daughters.

○ **Logan E. Hull**, Chevy Chase, Md.; University of Pittsburgh School of Medicine, 1910; age 84; died October 12, 1970. He served as chief of obstetrics at Altoona Hospital until 1951. He is survived by four children, two of whom are doctors, L. Ben Hull, M.D., and William H. Hull, M.D.

○ **David J. Kirk**, Tyrone; Jefferson Medical College, 1929; age 65; died October 2, 1970. He practiced general medicine for thirty-six years in Tyrone until his retirement in 1968. He is survived by his wife, two sons, a brother and a sister.

○ **Paul E. Kubasko**, Throop; Georgetown University School of Medicine, 1921; age 71; died September 21, 1970. Dr. Kubasko had been associated with the Lackawanna County coroner's office for almost four decades and was a widely known surgeon of the area. Surviving are two sons.

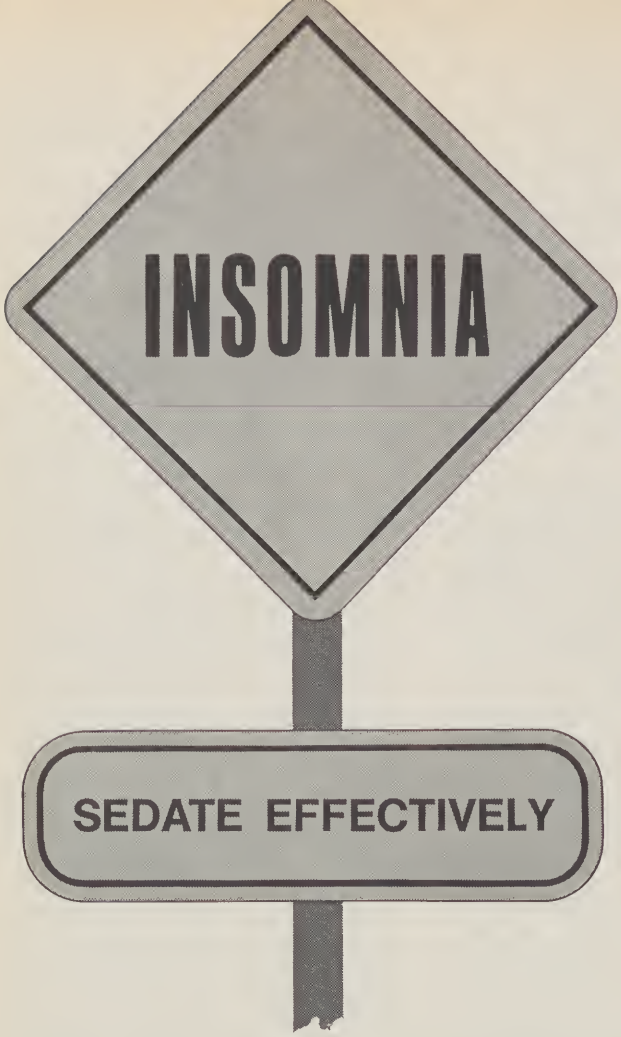
○ **Ruth C. Moore**, Ephrata; Medical College of Pennsylvania, 1934; age 63; died October 24, 1970. During World War II she served as a medical missionary in Kuwait, Arabia, and after returning to the United States opened an obstetrics and gynecology practice in Lancaster and later in Ephrata. She was a past president of the Northern Lancaster County Medical Society. Surviving are her husband and a daughter.

○ **Herman W. Ostrum**, Philadelphia; University of Pennsylvania School of Medicine, 1917; age 77; died October 22, 1970. Dr. Ostrum was emeritus professor of radiology at the Hospital of the University of Pennsylvania. The Herman Ostrum Radiological Prize Fund has been created at the university in his honor. Dr. Ostrum was also a past president of the Philadelphia Roentgen Ray Society and past vice-president of the Philadelphia County and Pennsylvania Medical Societies. He is survived by his wife, a daughter and two sons, Gordon Ostrum, M.D., and Bernard Ostrum, M.D.

M. Weir Kneedler, St. Petersburg, Fla.; Harvard University School of Medicine, 1924; age 74; died October 23, 1970. Formerly of Pittsburgh, Dr. Kneedler had served as staff member emeritus of Suburban General Hospital in Bellvue until his retirement in 1954. His wife and a daughter survive.

David W. Norton, North Apollo; Temple University School of Medicine, 1955; age 41; died November 13, 1970. Until his death he practiced at the Russelton Medical Group Clinic in North Apollo and became affiliated with Pittsburgh and Columbia Hospitals in Pittsburgh. Surviving are his wife, a son and two daughters.

Nancy S. Kintzing, Hanover; The Medical College of Pennsylvania, 1939; age 55; died November 3, 1970. Dr. Kintzing had been a pediatrician and instructor for expectant parents' classes. Surviving are her husband, a daughter, two sons and a sister.



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wenty-Fourth National Conference on Rural Health, March 25-26, 1971, Atlanta Marriott Motor Hotel, Atlanta, Ga.

ennsylvania Committee on Trauma of the American College of Surgeons and Pennsylvania Nurses' Association present "Selected Topics for Emergency Room Care," March 12, 1971, Hershey Medical Center, Hershey. Registration may be obtained through the Pennsylvania Committee on Trauma, American College of Surgeons, c/o W. E. DeMuth, M.D., Chairman, 17 S. West St., Carlisle 17013.

MAY

)mprehensive Symposium in the Diagnosis and Treatment of Strabismus," May 5-7, 1971, Eye and Ear Hospital, Pittsburgh. For information and registration contact K. Richardson, M.D., Chairman, Department of Ophthalmology, Eye and Ear Hospital, Pittsburgh 15213.

cond National Conference on Breast Cancer, May 17-19, 1971, Century Plaza Hotel, Los Angeles, Calif.

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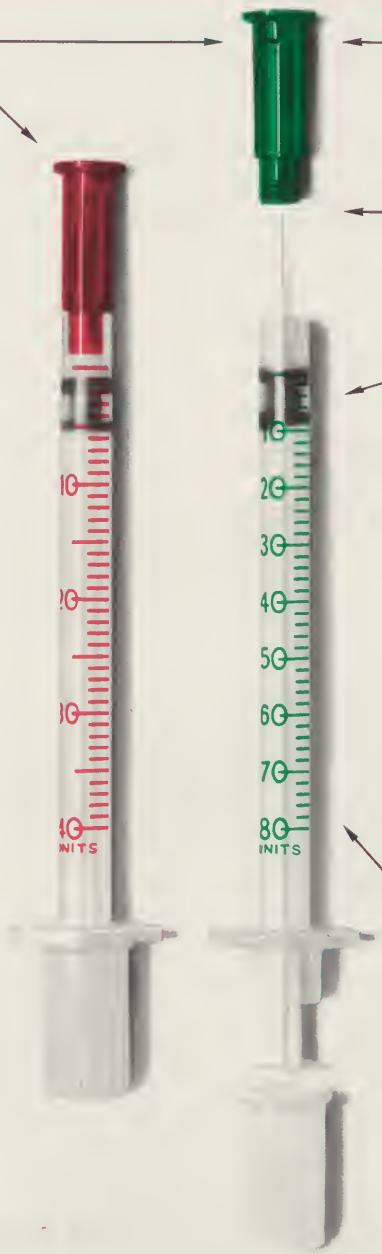

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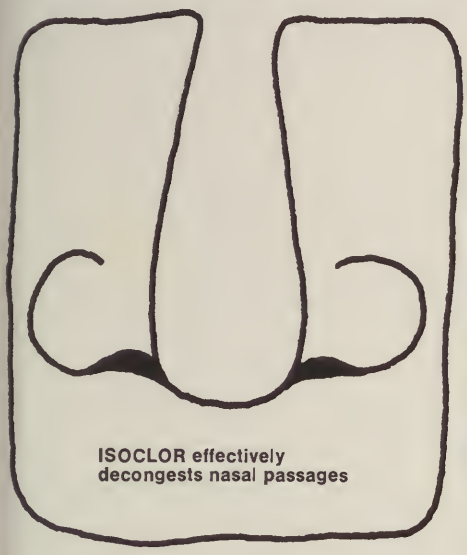

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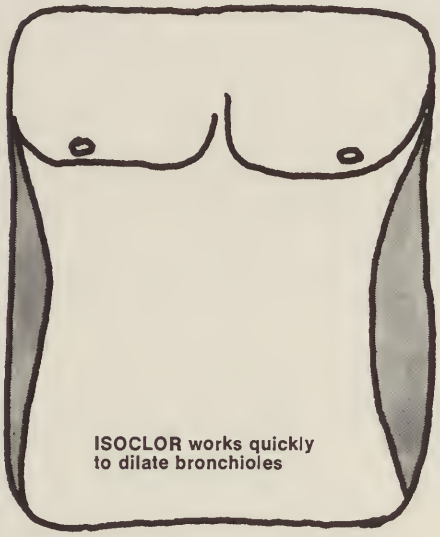

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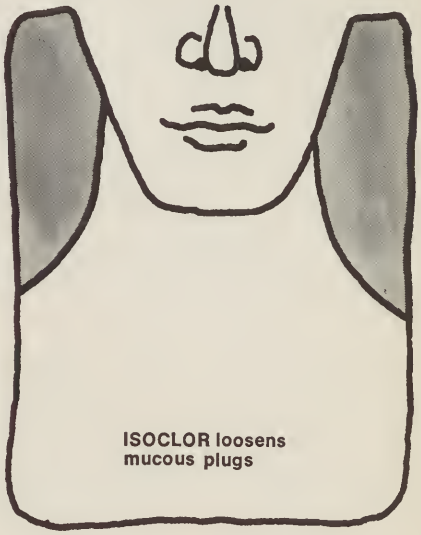
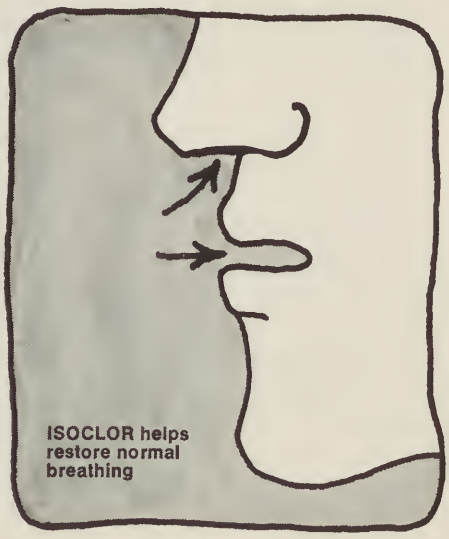


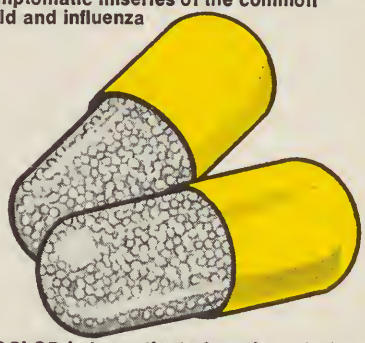
ISOCLOR loosens mucous plugs

ISOCLOR relieves runny eyes



ISOCLOR helps restore normal breathing

ISOCLOR promptly and effectively combats symptomatic miseries of the common cold and influenza



ISOCLOR helps patients face the cold facts

ISOCLOR®

Isoclor provides quick, long lasting relief of respiratory congestion and discomfort brought on by common colds, influenza, and allergies. Isoclor contains chlorpheniramine maleate — one of the most potent and safest antihistamines. And pseudoephedrine HCl — a decongestant bronchodilator providing effective and long lasting relief for the entire respiratory tract. Both work to extend the range of relief.

COMPOSITION: Each tablet or 2 teaspoonfuls of liquid contains:
Chlorpheniramine Maleate ..... 4 mg.
Pseudoephedrine HCl ..... 25 mg.

Each ISOCLOR Timesule contains:

Chlorpheniramine Maleate ..... 10 mg.
Pseudoephedrine HCl ..... 65 mg.
In a special pellet form providing both prompt and sustained effect.

INDICATIONS: For symptomatic relief of colds, hay fever, allergic conjunctivitis, perennial rhinitis of allergic origin and sinusitis. Opens nasal, sinus and bronchial passages orally.

CONTRAINDICATIONS: Sensitivity to antihistamines or sympathomimetic agents. Severe hypertension or severe cardiac disease.

PRECAUTIONS: Use with caution in patients suffering with hyperthyroidism. Patients susceptible to the soporific effects of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

CAUTION: Federal law prohibits dispensing without prescription.

SUPPLIED: Tablets: Bottles of 100 and 1000. Liquid: 4 oz. bottles, pints, and gallons; Timesules: Bottles of 50, 250, and 1000.

DOSAGE AND ADMINISTRATION:	Tablets	Liquid	Timesule
Adults:	1 q. 4 h.	2 tsp. q. 3-4 h.	1 q. 12 h.
Children 6-12 years:		1 tsp. q. 3-4 h.	
40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

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Mount Prospect, Illinois 60056

When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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PENNSYLVANIA MEDICINE

MARCH, 1971

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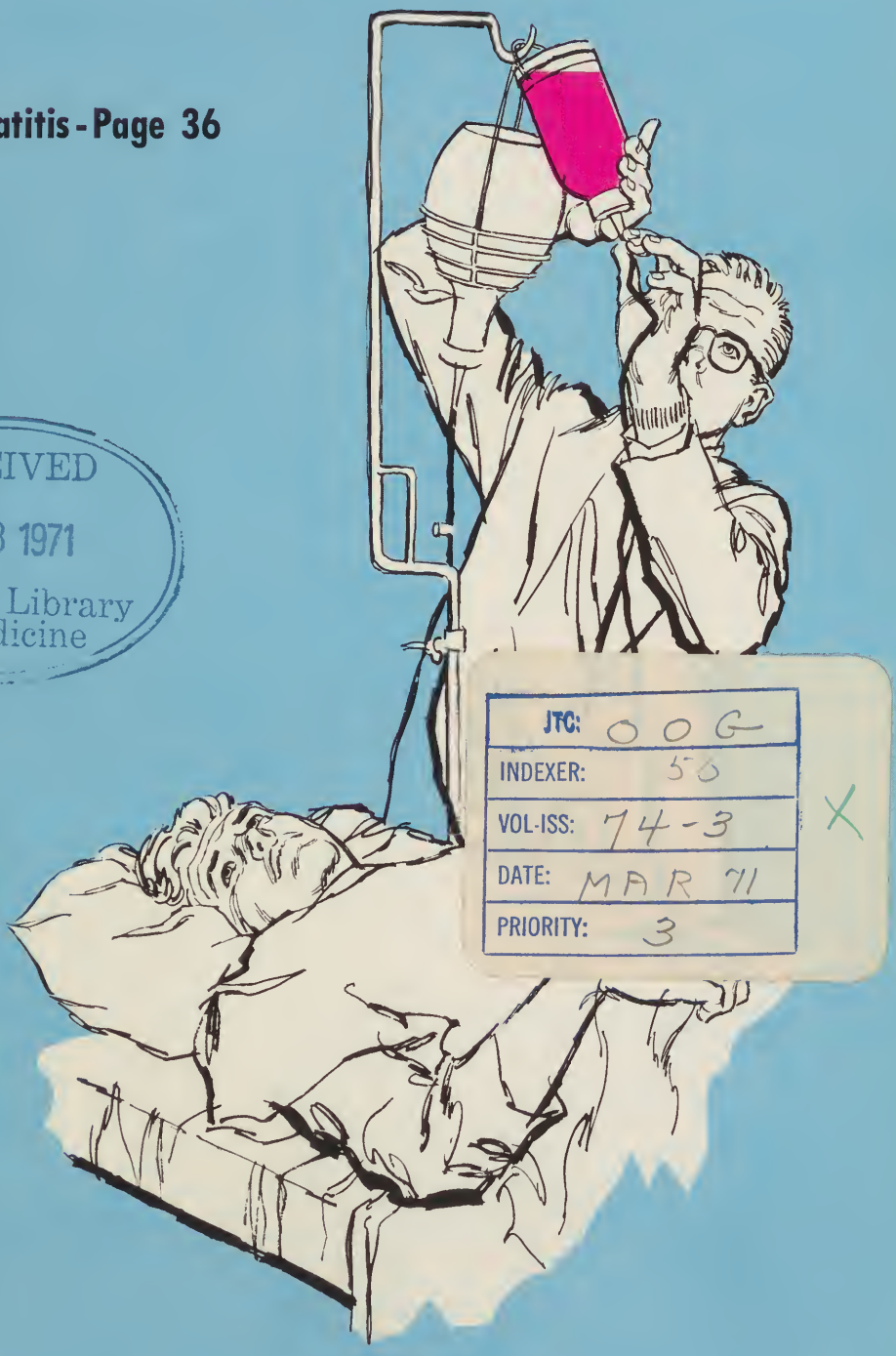

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IF MORE MEN CRIED

At least seventy-five out of one hundred adults with duodenal ulcers are men.[1] Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."[2]

Hypersecretion—an atavistic response. Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."[2]

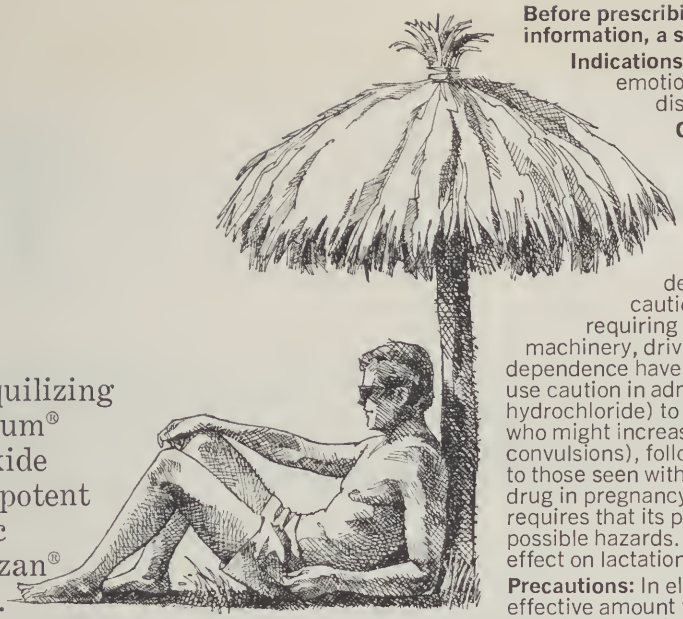
By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."[3]

Big boys don't cry. If more men cried, maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total of their genes and what they are taught. Schottstaedt observes that when a mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism.[4] Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age.

Take away stress, you can take away symptoms. There is no question that stress plays a role in the etiology of duodenal ulcer. Alvarez[5] observes that many a man with an ulcer loses his symptoms the day he shuts up the office and starts out on a vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

The rest cure vs. the two-way action of Librax.® For most patients, the rest cure is as unrealistic as it is desirable. Still, the stress factor must be dealt with. And here is where the dual action of adjunctive Librax can help. Librax is the only drug that com-

References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, M. M. *et al.* (eds.): *Harrison's Principles of Internal Medicine*, ed 6, New York, McGraw-Hill Book Company, 1970, p. 1444 2. Wolf, S., and Goodell, H. (eds.): *Harold G. Wolff's Stress and Disease*, ed. 2, Springfield, Ill., Charles C Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schottstaedt W. W.: *Psychophysiologic Approach in Medical Practice* Chicago, Ill., The Year Book Publishers, Inc., 1960, p. 163 5. Alvarez, W. C.: *The Neuroses*, Philadelphia, Pa., W. B Saunders Company, 1951, p. 384.



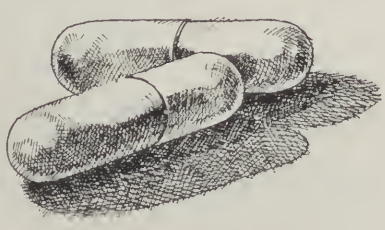
)ines the tranquilizing
ction of Librium®
(chlordiazepoxide
HCl) with the potent
nticholinergic
ction of Quarzan®
clidinium Br).

Protects man from his own hungry personality. The action of Librium reduces nxiety—helps protect the vulnerable patient rom the psychological overreaction to stress hat clutches his stomach. At the same time, he action of Quarzan helps quiet the hyperctive gut, decreasing hypermotility and ypersecretion.

An inner healing environment with 1 r 2 capsules, 3 or 4 times daily. Of course, here's more to the treatment of duodenal lcer than a prescription for Librax. The paent—with your guidance—will have to adust to a different pattern of living if treatent is to succeed. During this adjustment eriod, 1 or 2 capsules of Librax 3 or 4 times aily can help establish a desirable environent for healing.

Librax: It can't change man's nature. ut it can usually make it easier for men to ope with the discomfort of stress—both sychic and gastric—that can precipitate ad exacerbate duodenal ulcer.

Librax: Rx #60 1 cap. *a.c.* and 2 *h.s.*



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

in the treatment of duodenal ulcer

adjunctive

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

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Makes water, not waves.

Electrolyte imbalance may occur when using diuretics. Hygroton is contraindicated in severe renal or hepatic diseases and, of course, if it causes hypersensitivity. Carefully supervise those who may be receiving other antihypertensives.

Hygroton® chlorthalidone USP *Indications:* Hypertension and many types of edema involving retention of salt and water. *Contraindications:* Hypersensitivity and most cases of severe renal or hepatic diseases. *Warnings:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant women and nursing mothers since the drug crosses the placental barrier and appears in cord blood and since thiazides appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus. *Precautions:* Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. *Adverse Reactions:* Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization. *Average Dosage:* 50 or 100 mg. with breakfast daily or 100 mg. every other day. *How Supplied:* White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000. (B)46-230-G *For full details, please see complete prescribing information.*

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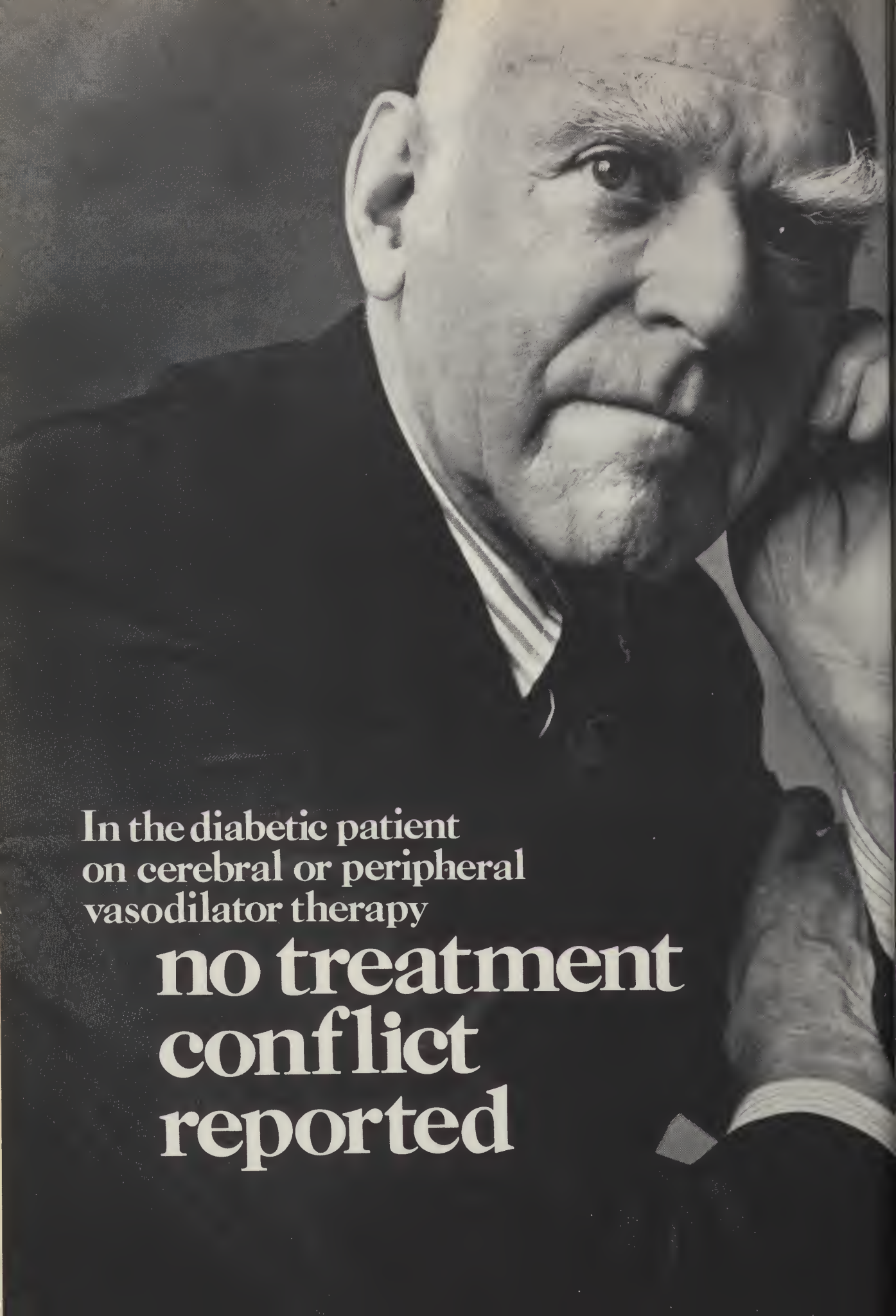
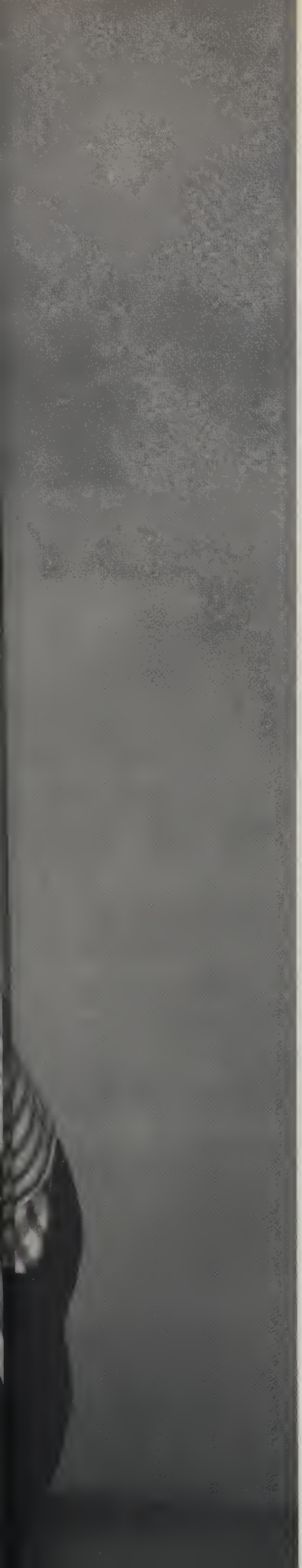

In the diabetic patient
on cerebral or peripheral
vasodilator therapy
no treatment
conflict
reported



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(ISOXSUPRINE HCl)

the compatible vasodilator

- no interference with diabetic control ...does not alter carbohydrate metabolism.[1]
- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.
- complications in the treatment of coronary insufficiency, hypertension, peptic ulcer, glaucoma and liver disease have not been reported.

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[2-5] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[3,5] and observation of clinical improvement.[2,4]
Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Composition:** VASODILAN tablets, isoxsuprine HCl 10 mg, and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications and Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories. **References:** (1) Samuels, S. S., and Shaftel, H. E.: J. Indiana Med. Ass. *54*:1021-1023 (July) 1961. (2) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. (3) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (4) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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an economical prednisone that's made a name for itself

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

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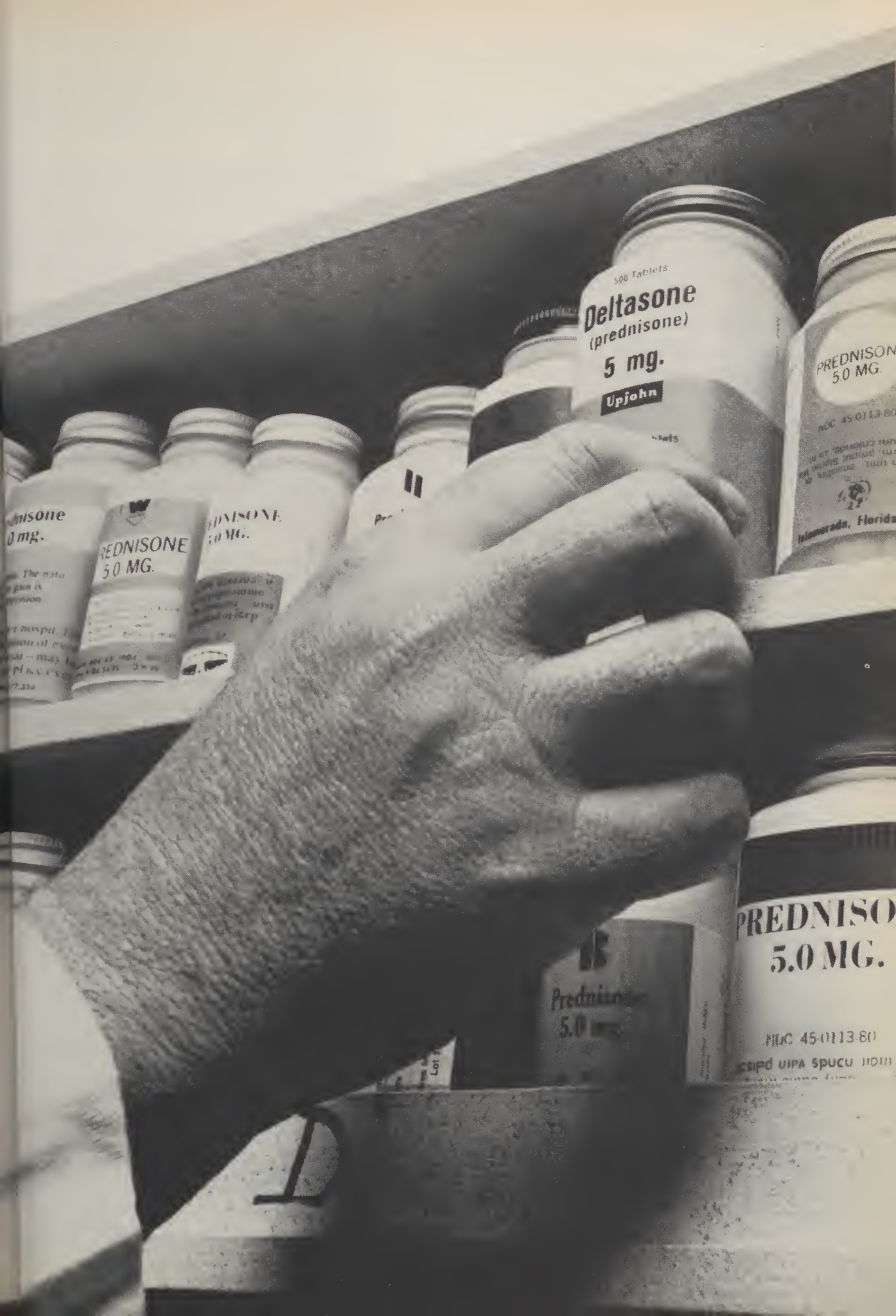
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Deltasone
(prednisone)
5 mg.
Upjohn
PREDNISONE
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PREDNISONE
5.0 MG.
PREDNISO
5.0 MG.
NDC 45-0113-80

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(prednisone, Upjohn)

The potency of prednisone exceeds cortisone in glucocorticoid and anti-inflammatory activity by about five times on a weight basis, but is considerably less active than cortisone in mineralocorticoid activity.

Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. *Important:* Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptomatically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance doses of Deltasone (prednisone), however, keep this ef in mind and perform periodic serum potassium determination patients on prolonged corticoid therapy. Muscle weakness oc ring with normal serum potassium levels may be due to disturba in muscle metabolism. Severe myopathy is associated with s stantial doses of steroids for prolonged periods, and evide indicates it occurs more frequently with 9-alpha-fluro steroids. placement with non-fluorinated steroid has, in some instances, sulted in improvement.

Retardation of linear growth, roughly proportional to dose, been noted in children on corticoids for six months or more. Foll ing cessation of therapy, growth rate may be accelerated. The fore, carefully observe growth of children on prolonged cortic and if growth is retarded, reduce dose sufficiently to permit reco before epiphyseal closure. Make every effort to avoid cortic during pregnancy, since spontaneous remission of some disea such as rheumatoid arthritis may occur. Long term corticoid ther may evoke hyperacidity or peptic ulcer, therefore, as prophyla an ulcer regimen and antacid are highly recommended. Take X-r in peptic ulcer patients complaining of gastric distress, a whether or not changes are noted, an ulcer regimen is rec mended. Since prednisone causes less salt and water reten than many other glucocorticoids, patients should be obser closely for development of undesirable hormonal effects that less obvious indications of steroid toxicity than edema and hyp tension due to salt and water retention. Continued supervisio patients after cessation of therapy is essential, since there may a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of c coids include: Cushing's syndrome, moon facies, supraclavic fat pads, hirsutism, striae and acne; relative adrenocortical ins ciency particularly in time of stress due to trauma, surgery severe illness; protein catabolism with negative nitrogen balar electrolyte imbalance; alteration of glucose metabolism with agg vation of diabetes mellitus including hyperglycemia and glycosu osteoporosis reversible only with difficulty; spontaneous fractu aseptic necrosis of the hip and humerus; activation and compli tion of peptic ulcer including perforation and hemorrhage; agg vation or masking of infection; increased blood press convulsions; petechiae and purpura; menstrual irregularities cluding amenorrhea, spotting or prolonged bleeding; insom psychic disturbances especially abnormal euphoria; nervousn posterior subcapsular cataracts occasionally requiring extract increased intraocular tension; increased intracranial pressure papilledema (pseudotumor cerebri); pancreatitis; necrotizing a itis; thinning of scalp hair; suppression of growth in child thromboembolic complications; facial erythema; allergic skin re tions; ulcerative esophagitis; sweating; vertigo; weakness; my athy; headache; exophthalmos. Adverse reactions are usu reversible and usually disappear when drug is discontinued.

Supplied: 2.5 mg., scored—bottles of 100 tablets. 5 mg., score bottles of 100 and 500 tablets and cartons of 100 tablets in strips.

For additional product information, consult the package in or see your Upjohn representative.

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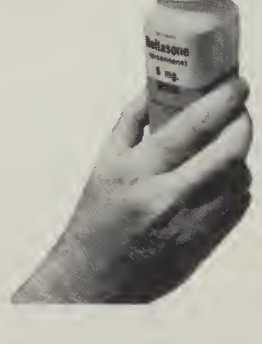

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PROPOSED LAW SCANNED The State Society has stated its analysis of House Bill 60, the "Voluntary Nonprofit Health Service Act of 1971," in a letter from PMS President William A. Limberger, M.D., to Representative Sarah A. Anderson, chairman of the House Committee on Health and Welfare. Dr. Limberger's letter said, "The bill is an effort to circumvent certain provisions in the 'Blue Shield Act' and the 'Blue Cross Act' which guarantee freedom of choice of physicians and hospitals; further, the bill would permit consumers to dominate boards of nonprofit health service corporations...the House of Delegates of the Pennsylvania Medical Society is on record as favoring experimentation in the delivery and financing of health services which are designed to provide the best quality comprehensive health care at the most reasonable cost; therefore we can have no real argument with these innovations assuming that the designers of this legislation and the eventual founders of these plans are as altruistic as we hope."...Consumer and labor groups studying the establishment of pre-paid practice plans in both Philadelphia and the Pittsburgh area are said to be urging passage of the legislation which would enable such groups to form in the Commonwealth.

'OUNDATION PLANS GROW The Subcommittee on Medical Care Foundation of the PMS Council on Public Service is oving forward in developing plans for the establishment of a statede medical care foundation. Full details will be ready for preentation to the 1971 House of Delegates. In Iowa and Missouri, imilar efforts are under way. The national movement toward establishment of such foundations by medical societies is aimed at proiding the greatest amount of physician supervision and professional eview to the health services provided for the public.

HILADELPHIA M.D. NOMINATED Governor Milton J. Shapp has nominated a Philadelphia County public health fficial as secretary of health. J. Finton Speller, M.D., was chief f urology at Philadelphia General Hospital before joining the county ealth department in 1960. He now heads the social health section here. Dr. Speller is a member of the Philadelphia County and Pennylvania Medical Societies, the AMA, the Philadelphia Urologic ociety, and is a fellow of the American College of Surgeons.

MS ACTIVE ON MALPRACTICE SCENE The State Society Board of Trustees on March 17 will take nder consideration a proposal for a "Group Professional Liability nsurance Program" for PMS members. See pages 36 and 60 of this ssue for further news in the area of malpractice suits...PMS has

indicated its approval of a bill, Senate Bill 265, which would relieve physicians, hospitals and their employees from ordinary liability in emergency treatment of minors when reasonable efforts have been made to reach parents...The PMS letter suggested the bill be amended to include such exemption when physicians are participating in mass immunization programs approved by the Pennsylvania Health Department.

COMMONWEALTH MAKES MEDICAL NEWS Pennsylvania leads the nation in diabetes detection activities supported by the Pennsylvania Department of Health according to the Disease Detection Information Bureau, Chicago. The report showed the department's screening program tested 176,585 persons in the year ending June 30, 1970...Reports from the U.S. Center for Disease Control had preliminary figures showing that in 1970 the state had 2,117 cases of rubeola and 2,199 cases of rubella...It wasn't mass illness in the Welfare Department but lack of funds which delayed payments for treatment of recipients of state assistance. The department ran out of money in 1970. The new Legislature has passed a deficiency appropriation which needs only the governor's signature to permit payment of back bills.

MEDICAL EDITOR NAMED HOSPITAL DIRECTOR David A. Smith, M.D., medical editor of PENNSYLVANIA MEDICINE, was named medical director of Harrisburg Polyclinic Hospital at a recent meeting of the hospital's board.

MEDICAL LEGISLATION POTPOURRI President Richard M. Nixon has sent his health message to Congress. Included are proposals for national health insurance, aid to medical education, reorganization of the delivery of health care and meeting medical needs in scarcity areas...In Congress, the first bill introduced the House of Representatives, H.B. 1, proposes amendments to the Social Security Act. It is essentially the same bill which was adopted in the House in the spring of 1970, but which died when the Senate failed to act on it last year. The bill would make changes in medicare and medicaid provisions providing for a peer review mechanism and authorizing payments to Health Maintenance Organizations, among other changes. The bill is expected to be ready for a vote in the House early this month. On the state level new legislation introduced includes H.B. 220--"the Pennsylvania Blood Bank Act"-- which would permit the Department of Health to regulate and license blood banks; H.B. 414-- amending the Medical Practice Act to permit the State Board of Medical Education and Licensure to regulate training of physicians' assistants; and S.B. 36 to create a state board to license psychologists...A resolution has been introduced in the House of Representatives calling for a Joint State Government Commission study of the medical and osteopathic schools of the state. The resolution says increased state appropriations have not increased the number of graduates proportionately.

PMS Produces Hour-Long Documentary

An hour-long television documentary program entitled "Health Care—The Coming Crisis" has been produced by the Pennsylvania Medical Society and steps are underway to place it on various stations across the state.

The PMS Council on Public Service, the group responsible for the program's production, gave final approval to a work copy of the documentary on Saturday, February 13, and the editing and production steps necessary for finished copies are underway.

Meetings are being held with television station officials across the state to establish showing times and dates. Announcements will be made as soon as the stations, dates and times have been determined.

The program was produced on a financial shoestring by having the State Society Council on Public Service staff, with almost the entire workload falling to James P. O'Leary, do all of the research, script writing, producing, narrating and directing. The only skills hired by the staff were those of a cameraman.

What's it all about?

The decision to attempt a documentary production came in the aftermath of last year's two-part television documentary on health care produced and shown by the Columbia Broadcasting System. Those programs presented what medical spokesman feel was a distorted view of the health and medical care delivery problem and the only solution to the problems offered by CBS was that medical care should be socialized.

The Pennsylvania Medical Society documentary takes an objective look at today's problems, describes some of the efforts that are being made to combat them and then stresses what it believes to be the primary cause of the existing and coming problems—the growing lack of medical and other health care manpower. It points out that no system imposed on the existing number of physicians will be able to increase their output beyond the average 65-hour week they already are meeting. It concludes that increased support for medical schools to turn out more physicians is the only logical first-step answer to the current and predictable medical care delivery problems.

The program includes looks at urban health center projects in Philadelphia and Pittsburgh. It examines some of the problems in rural areas. It shows the growing use of hospital emergency departments and it features interviews with medical school spokesmen and state educators. The program concludes with a summarizing statement by PMS President William A. Limberger, M.D.

State Society officials and staff members will be meeting with television station personnel this month (March) in an effort to establish firm viewing dates and times and these will be announced as soon as they have been determined.

With little or no modification, the program also can be made available as a film for showing to public and professional groups.

(See photos on Page 12)

THOMAS W. McCREARY, II, M.D., president of the State Society ten years ago and delegate from PMS to the AMA House of Delegates for twenty-three years, has resigned as delegate. He served as chairman of the delegation for the past four years. Dr. McCreary retired from active practice at the end of 1970 after a career spanning almost fifty years, during which time he established and directed the clinical pathology laboratory at Rochester Community Hospital.

VD Commission Created by HEW

Creation of a National Commission on VD to combat the diseases of gonorrhea and syphilis has been announced by Roger O. Egeberg, M.D., HEW assistant secretary for health and scientific affairs.

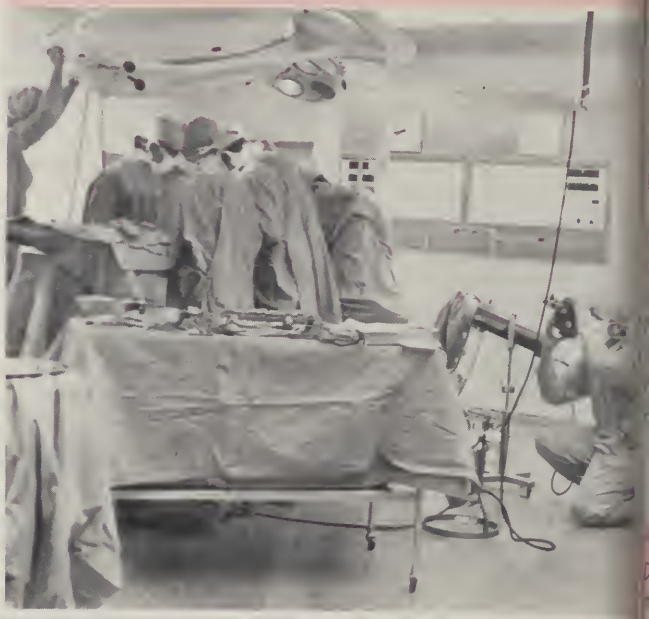
Bruce Webster, M.D., New York City, president of the American Social Health Association, has accepted chairmanship of the commission.

In accepting the post Dr. Webster said, "In 1968, a national incidence survey conducted by the American Social Health Association for the Public Health Service found that although private physicians treat about 80 per cent of the venereal disease cases, they report only one in nine to public health officials. We believe that this commission will serve as the long-needed link between public health and private medicine."

Dr. Webster said that ASHA estimates that last year there were approximately 2,000,000 cases of gonorrhea in the U.S., and 75,000 cases of infectious syphilis.

Early in 1969, ASHA was asked by the American Medical Association, National Medical Association, and American Osteopathic Association to convene twenty-three health and medical organizations for the purpose of discussing a national VD prevention and control policy. Out of the meeting which followed came the plan for a national commission.

PHOTOGRAPHING the TV photographer was jus part of the job of James P. O'Leary, PMS Counci on Public Service staff assistant, who did the bull of the work in producing the PMS TV documenta ry, "Health Care—the Coming Crisis." Shown lef are, left to right, photographer Edward Hoffma and Mr. O'Leary. The two shots below, taken b Mr. O'Leary, show Mr. Hoffman in action with hi camera in the OR.



PGH Opens Extended Care Facility

An extended care facility for the chronically ill and aged who are patients at Philadelphia General Hospital has been opened in the Mills Building of the hospital, PGH Executive Director Elton W. Barclay has announced.

"There are presently about 200 elderly patients at PGH who are not in need of acute care, but who do need the kind of nursing care that a nursing home or extended care facility can provide," Barclay said.

"Unfortunately, since these are poor people, dependent upon welfare, private nursing homes in the city will not accept them because the funds provided by the state, $11 a day, are not adequate, and the city's home for the aged, Riverview, already is at peak capacity."

Barclay noted that the special facility has been established in an effort to meet the needs of these older people. "It will only be for those individuals who have been patients at PGH and who have no homes to return to, or for whom nursing home placements cannot be obtained," he said.

The first unit, now in operation, has space for 132 long-term-care beds. Future plans call for the addition of another seventy beds. It is anticipated that the extended care unit will eventually meet state and federal standards for reimbursement under the provisions of Medicare, Medicaid, and state nursing-home payments, Barclay said.

"COMPULSORY HEALTH INSURANCE" was the subject of a panel discussion at the February meeting of the Dauphin County Medical Society. The dinner meeting was preceded by a special session for council and committee members of the society. Shown below, left, PMS President William A. Limberger, M.D. makes a point in explaining the functions of the State Society. Below to the right Executive Director John F. Rineman explains the ways dues work for the membership. In the photo above are Paul S. Friedman, M.D., Philadelphia, who moderated the discussion on health insurance; Claude E. Nichols, M.D., Harrisburg, program chairman for the county society; William O. LaMotte, Jr., M.D., Wilmington, Del., chairman of the AMA Council on Legislation; and Michael Johnson, executive vice-president of the Pennsylvania AFL-CIO.

Future Plans Outlined

Geisinger Board Hears Report

Leonard F. Bush, M.D., chief of staff at Geisinger Medical Center, Danville, summarized the future of the center at a recent meeting of the Board of Directors.

"I would expect that by 1975 our bed capacity probably will reach 550 or more and our physicians will number 100," he predicted. His report dealt with plans for 1971, as well as a 10-year projection of future expansion. Walter I. Buehert, M.D., medical director, and F. Kenneth Ackerman, Jr., administrative director, presented the advances and changes which have taken place during the past year.

Statistically, 1,191 new patients were admitted at Geisinger — nearly an 11 per cent increase over 1969, while outpatient visits jumped more than 12 per cent, and consultations among physicians rose 21.7 per cent. The number of operations, laboratory tests, x-ray examinations, and other ancillary services increased accordingly.

In connection with the outpatient statistics, Dr. Buehert stated, "This accelerated growth documents the center's policy to emphasize preventive medicine, outpatient diagnosis and treatment, and the round-the-clock availability of emergency care."

The report emphasized the need to give continued attention to cost effectiveness by training new categories of medical personnel, such as physicians' assistants or aides.

Progress was reported in broadening the work week at Geisinger to make greater use of facilities on weekends. Dr. Buehert also indicated the center's willingness to explore the feasibility of total prepayment of health care with health insurance companies or organized medicine. This would be coordinated with cooperative efforts of agencies, medical facilities, and physicians in central Pennsylvania in an effort to improve the health care delivery system.

The house staff of seventy interns and residents in 1969-70 was the largest in the history of the medical center. Applications of senior students from twenty-seven medical schools for 1971-72 already have been received.

In 1970 the eighty-one physicians on the medical staff spent more than 11,000 hours in medical teaching conferences. A basic science class for updating scientific knowledge is in the planning stage.

Last year the center's institute of medical education and research was designated by the Pennsylvania Science and Engineering Foundation to carry out regional responsibilities for a twenty-county area. The institute also administers several paramedical training programs and twenty-six projects in progress at Geisinger.

In keeping with trends in nursing education, Geisinger's school of nursing revised its program from a three-year to a two-year course applicable to the class entering next fall.

Dr. Bush feels that plans for a multiphase outpatient screening clinic emphasizing preventive medicine demands priority, and he recommended a minor surgical unit for patients who require a few hours of bed recovery but do not need an overnight stay.

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Philadelphia Asks Grant For Addiction Centers

The city of Philadelphia has applied for $293,835 of federal funds to establish a methadone treatment program for heroin addicts. The city's share of the costs would be $125,930.

Initially the program will seek to establish two treatment centers with a total capacity of 400 addicts, at a cost of $419,165 for the first year. Eventually it is hoped to establish seven units throughout the city, each with a capacity of 200 addicts, or a total of 1400.

The application will be forwarded to the Law Enforcement Assistance Administration (LEAA) of the U.S. Department of Justice by the Office of Mental Health and Mental Retardation, city health department.

Target areas for this beginning phase of the program would be Mental Health Catchment Area 1 (served by the Hahnemann Comprehensive Community Health Center) and Area 2A (served by the Pennsylvania Community Mental Health/Mental Retardation Center).

In addition to the methadone medication, treatment would involve group therapy, peer pressure groups, and marital and family counselling groups. Rehabilitation would be stressed and close ties would be established with the State Bureau of Vocational Rehabilitation and other appropriate community service agencies.

All addicts would be registered with the Base Service Unit of their appropriate Community Mental Health/Mental Retardation Center and the center would be expected to provide psychiatric, social, and other back-up services, just as they would for any other area residents with a mental disability.

Attack At Source

PMS Supports Great Lakes Pollution Control

A request for state action to support the establishment of a U.S.-Canadian regulatory body to control pollution in the entire Great Lakes drainage basin has been made by the Pennsylvania Medical Society.

The recommendation was made in a letter to Dr. Maurice K. Goddard, acting secretary of the newly-established Pennsylvania Department of Environmental Resources, from PMS Board of Trustees Chairman Park M. Horton, M.D. It was one of several recommendations developed in a meeting of medical societies from seven states and two Canadian provinces.

The PMS Board of Trustees approved the suggestions at the recommendation of the Commission on Environmental Health. Other actions urged by the State Society include:

1. Limiting the addition of phosphates to receiving water in the Great Lakes watershed.

2. Giving high priority to enlargement of existing sewage treatment plants and installation of new plants in the watershed area, emphasizing that municipalities must move as rapidly as possible to attain complete sewage treatment.

3. Finding means to convert waste materials to useful purposes (such as phosphates to fertilizers).

4. Mandating that both emission and water quality standards be developed and that uniform water quality techniques, prescribing pollutants to be measured, be used.

The recommendation regarding the formation of an international regulatory body urged that the group have full regulatory powers and that the United States and Canada negotiate whatever treaty is necessary to establish such a regulatory body.

Auxiliary Names Three To Board

The Executive Committee of the Woman's Auxiliary of the Pennsylvania Medical Society has nominated the following members to serve as members-at-large of the PaMPAC Board of Directors: Mrs. George W. Utterson of Pittsburgh, Mrs. Edward J. Benz of Bethlehem, and Mrs. Franklin G. Wade of Williamsport. They will serve a one-year term, and may be renominated for a second term.

PMS Appoints Fourteen Members To Shield Corporate Membership

PMS Board of Trustees has appointed fourteen members-at-large to the corporate membership of the Medical Service Association of Pennsylvania (Blue Shield).

Reappointed are Joseph N. Corriere, M.D., Bethlehem, and Arthur J. McSteen, M.D., Greensburg, at-large representatives of the Society.

New appointees include: First Councilor District, Perry S. MacNeal, M.D., Philadelphia; Second District, Frank R. Boyer, M.D., Allentown; Third District, Vorrie B. Macom, M.D., Lansford; Fourth District, Harold B. Cooper, M.D., Schuylkill Haven; Fifth District, John H. Harris, Jr., M.D., Carlisle; Sixth District, James M. Campbell, Jr., M.D., State College; Seventh District, William D. Todhunter, M.D., Williamsport; Eighth District, Paul L. Barclay, M.D., Erie; Ninth District, Milton B. Brandon, M.D., Reynoldsville; Tenth District, Ralph J. Stalter, M.D., Pittsburgh; Eleventh District, Alexander Solosko, M.D., Salisbury; and Twelfth District, James J. Grace, M.D., Montrose.

Health Subjects On Forum Agenda

A human services forum, presented by Community Services of Pennsylvania (CSP) will be held March 16 and 17 in Harrisburg. The schedule for Tuesday, March 16, includes a reception at 5 p.m. at the Holiday Inn Town. At 6 p.m. buses will depart for the Penn Harris Motor Inn where a banquet will be held starting at 6:45 p.m. The keynote address will be given by Governor Milton J. Shapp.

Plans for Wednesday, March 17, are for special interest sessions beginning at 9:30 a.m. Luncheon will be at 12 noon, with more sessions from 1:30 through the afternoon. Morning sessions will cover new human services delivery systems, drug abuse, manpower, and housing. Topics for the afternoon sessions are family services and income, public health and medical care, and mental health and mental retardation.

TV Heart Seminar Scheduled April 14

A televised seminar, "Coronary Care in the Seventies," planned by the Susquehanna Valley Regional Medical Program's council on heart disease will feature John Chadbourne, M.D., St. Vincent's Hospital and Medical Clinic, New York; L. Loring Brock, M.D., Spalding Rehabilitation Center, Denver, Colo., and Emilio R. Guilani, M.D., Mayo Clinic, Rochester, Minn. It will be carried from 6:30-8:00 p.m., Sunday, April 4 by the following Pennsylvania stations:

WITF-TV (33) Hershey
WPSX-TV (3) University Park
WVIA-TV (44) Scranton-Wilkes-Barre
WLVT-TV (39) Allentown-Bethlehem
WQLN-TV (54) Erie

Audience participation will consist primarily of members of the council who will have the opportunity to question the panelists. Specific subjects to be discussed include management of the pre-hospital phase of acute coronary illness; the accomplishments of the coronary care unit; and rehabilitation of the patient after myocardial infarction.

Temple Receives Grant For Health Centers

An Office of Economic Opportunity (OEO) grant for $3,830,323 has been received by Temple University for the continued operation of the neighborhood health centers at Seventeenth and Tioga Sts. and 2539 Germantown Ave., Philadelphia.

As the health centers enter their fourth year, the OEO grant will go toward an expanded program. Heretofore, the centers could offer their services only to those persons who met the state's poverty-level standard, a large part of the area population.

"This year, that requirement has been waived and the entire community of some 43,000 persons may be served," said Curtis Owens, program administrator. "With the removal of that eligibility criteria," he added, "we have removed the stigma that was attached to the user of our services."

The centers meet the health needs of the community through teams of health providers—doctors, dentists, nurses, family health workers and social workers. Last year, about 18,000 persons, making about 79,000 visits, received health care at the centers.

The funds are channeled through the Philadelphia Anti-Poverty Action Commission to Temple University, the delegate agency. The Hartranft neighborhood center, at 2539 Germantown Ave., is operated jointly by Temple and St. Christopher's Hospital for Children.

No additional personnel will be needed to implement the expanded program, Owens pointed out.

To fill personnel needs, both centers draw heavily on local residents, who are given first opportunity to fill vacancies. In the two-and-a-half year period ended Dec. 31, 1969, more than $1.5 million went to these local residents in wages and salaries. Almost all of the professional staff members have faculty status at Temple University School of Medicine.

In addition to health care, the centers operate a training program for family health workers, who serve as the major liaison between the community and the centers.

Given multi-disciplinary training, these persons aid in screening and diagnostic testing and assist social service and nursing personnel. As members of the community, they often seek out those who need health care but don't know where to go, and direct them to specific areas in the centers.

This year, an additional source of money for the centers is expected to come from a pre-payment program recently negotiated with the state. It is based on a last year's cost-per-patient expenses incurred by the centers.

Professional Education Grows

The American College of Obstetrics and Gynecology (ACOG) has authorized its Committee on Continuing Education to offer a self-assessment test in gynecology and to repeat the 1971 self-assessment test in obstetrics at its 1972 clinical convention.

Jefferson Opens New CCU

The formal opening of the new cardiac care unit at Thomas Jefferson University Hospital revealed a new look, reflecting progress in the treatment of heart disease. The unit is L-shaped with a twelve-bed capacity for seven coronary patients and five cardiac surgery patients.

Leslie Wiener, M.D., associate professor of medicine at Jefferson Medical College is director of the medical section of the unit, with Benjamin Bacharach, M.D., clinical assistant professor of surgery, directing the surgical section.

Hahnemann Team Says Diuretics Affect Heart

Diuretics may have a direct action on the heart muscle as well as on the kidney, according to a team of investigators at Hahnemann Medical College and Hospital. Studies in animals indicate that potent diuretics such as ethacrynic acid and furosemide when used with digitalis may cause serious irregularities of heart beat because, in combination, they deplete the heart muscle of essential potassium. Further, potassium-sparing drugs such as triamterene and amiloride when used with digitalis seem to protect the heart's potassium supply and prevent arrhythmias.

Reporting to the American College of Cardiology in Washington, Robert H. Seller, M.D., associate professor of medicine and head of the heart failure clinic at Hahnemann, explained that potent diuretics which are used in the management of high blood pressure, heart failure and edema, are often given to patients who are taking digitalis. These diuretics are known to cause loss of potassium by the kidneys and to lower the potassium in the blood. However, the new work demonstrates that they may also cause the loss of this electrolyte from the heart, and may cause serious heart irregularities.

New Careers Planned In Mental Health

A "hire now — train later" career program in the undermanned mental health field was announced today by HEW's National Institute of Mental Health (NIMH), Health Services and Mental Health Administration.

Launched with more than $2.5 million in federal aid, the program will provide training for some 1,150 workers in 13 public agencies across the country.

"The policy of hire now, train later will help bring local, untrained people into programs where serious shortages now exist," NIMH Director, Bertram S. Brown, M.D., said.

"The traditional practice of hiring only people who have had training has affected two vital segments of our economy — agencies which need help but cannot find it and people who need employment but are not trained for it," he added.

In addition, the program will allow for upgrading and increased mobility for agency employees through further training and education.

It will serve as a national model to demonstrate how entry level personnel can be recruited from the community and then trained while actually on the job. It will also demonstrate how existing agency personnel can be upgraded or given greater mobility within their agencies.

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Another Opinion On M.D. Shortage Offered

The oft-cited shortage of qualified personnel in the various health-care professions is a myth, according to Temple University professor Milton W. Hamilt, M.A., who is also a consultant on hospital administration.

"Rather than a shortage of doctors, nurses and other health personnel," Hamilt said, "There is actually a plentiful supply which is maldistributed throughout the nation. The result in the case of doctors is a surplus in many metropolitan areas and a scarcity in rural pockets. ... Major cities such as New York, Boston, and Philadelphia have many more doctors than the health needs of the population require. In New York City alone, one-fourth of all physicians do not even have staff privileges at any hospital," he contends.

The lure of the metropolitan life with its accompanying educational, social, and cultural benefits has been traditionally one of the prime factors behind this phenomenon of medical talent maldistribution, according to Hamilt.

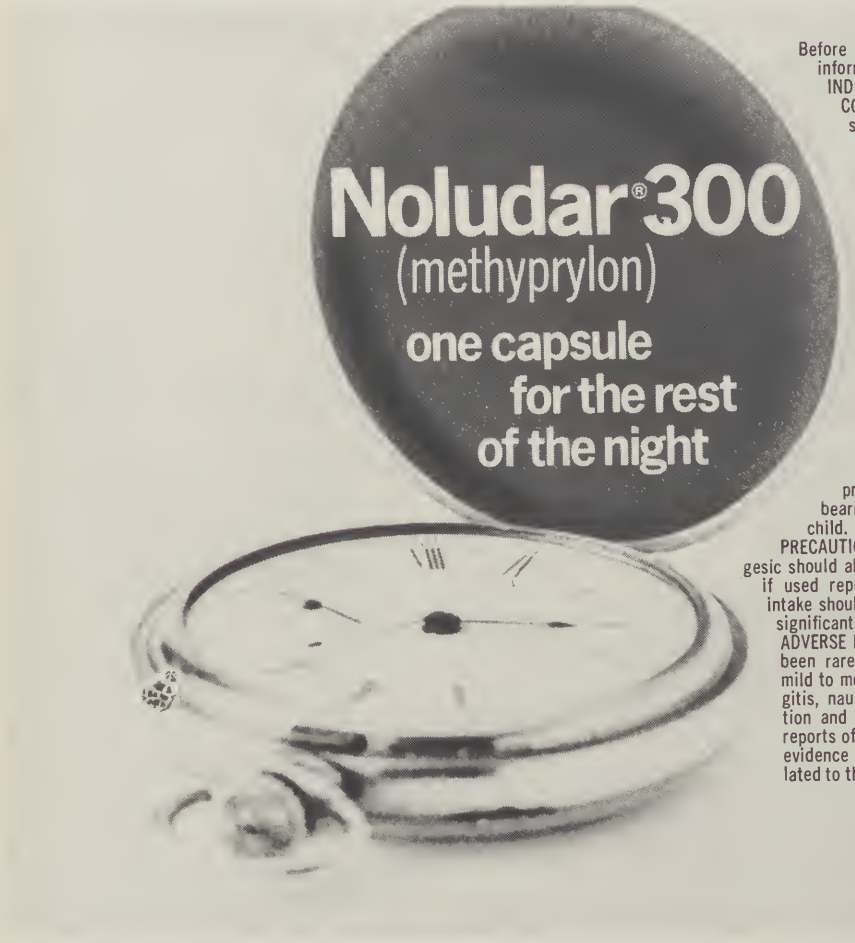
"The decade of the seventies will see thousands of young medical school graduates reevaluate the assets of rural practice. The seemingly insoluble problems of pollution, traffic congestion, housing, crime, and high taxes that affect life in metropolitan areas are almost alien concepts in most rural and agricultural areas where the need for medical care is gravest at this time," he said.

'Rather than a shortage of doctors...there is...a plentiful supply which is maldistributed...'

"The rapid growth of group practices will help balance out the supply of the country's medical talent. A recent survey in Illinois indicated that 85 per cent of all medical school seniors, interns, and residents polled show a strong interest in the group-practice field, where physicians share responsibilities, profits, facilities, and administrative staffs."

Group practices vary in size from the two or three-man office to the massive Geisinger Clinic, located in the small town of Danville, Pennsylvania, Hamilt notes. These islands of professionalism, according to Hamilt, often offer a brand of medical treatment that is superior to that found in urban hospitals.

"Consequently, there are serious questions about the merit of expanding existing medical schools and educational facilities which are now located primarily in metropolitan areas and therefore only contributing to the existing geographic imbalance of doctors," he concluded.



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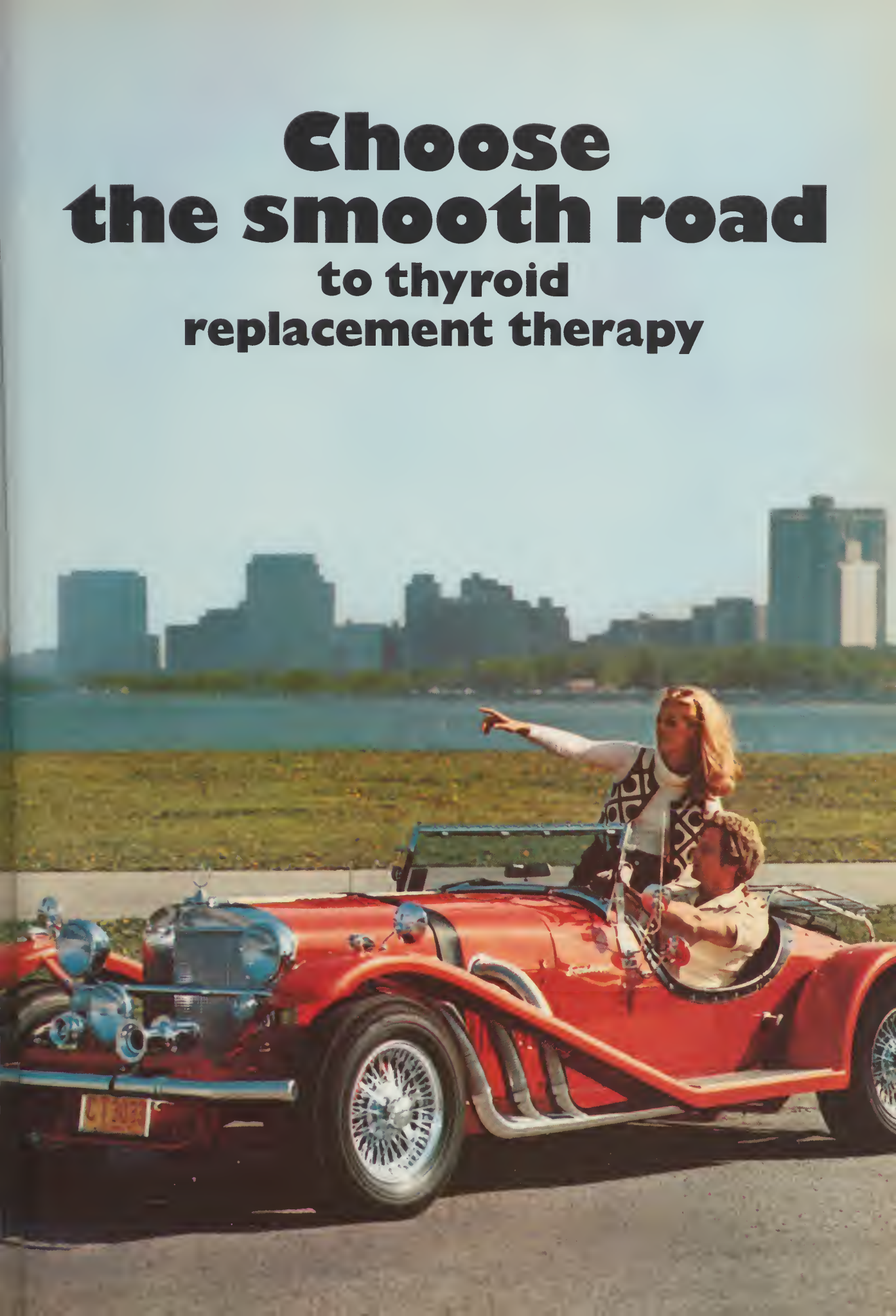

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Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmond's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.
Contraindications: Thyrotoxicosis, acute myocardial infarction.
Side effects: The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.
Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).
Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100 and 500. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) INJECTION may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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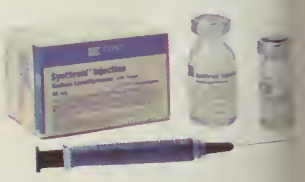
A new book, soon to be published, is devoted to the clinical aspects of hypothyroidism. The author, a leading endocrinologist, describes the many faces of the condition and emphasizes the importance of clinical assessment of the patient. Write, or ask your Flint man, to be placed on our list to receive a free copy.

2 NEW THYROID FUNCTION TEST BOOK: Newly published *Guideposts to Thyroid Therapy* discusses the tests most appropriate for use with each type of thyroid medication. Fully describes thyroid function tests and places their relative values in perspective for physicians. It will give you valuable new insights into the role of these tests in diagnosis and treatment. FREE—ask your Flint man.

3 TO START THERAPY, FREE TAB-MINDER dispensing units, color-coded to match colors of SYNTHROID tablets in starting dosage strengths. TAB-MINDER helps patients to regularly take the thyroid dosage you prescribe, avoid medication errors. Ask your Flint man.

FREE MEDICATION DISPENSERS TO START ALL YOUR PATIENTS ON SYNTHROID, IN THESE STRENGTHS: 0.05 mg. (white); 0.1 mg. (yellow); 0.15 mg. (violet); 0.2 mg. (pink).

4 SYNTHROID® INJECTION FOR THYROID EMERGENCIES: Whenever (as in myxedema coma) rapid replacement of thyroid hormone is needed to sustain life, prompt clinical response is essential. SYNTHROID INJECTION makes this therapy instantly available. Useful also in postoperative thyroid medication situations until oral therapy can be reinstated. Ask your Flint man for further information.



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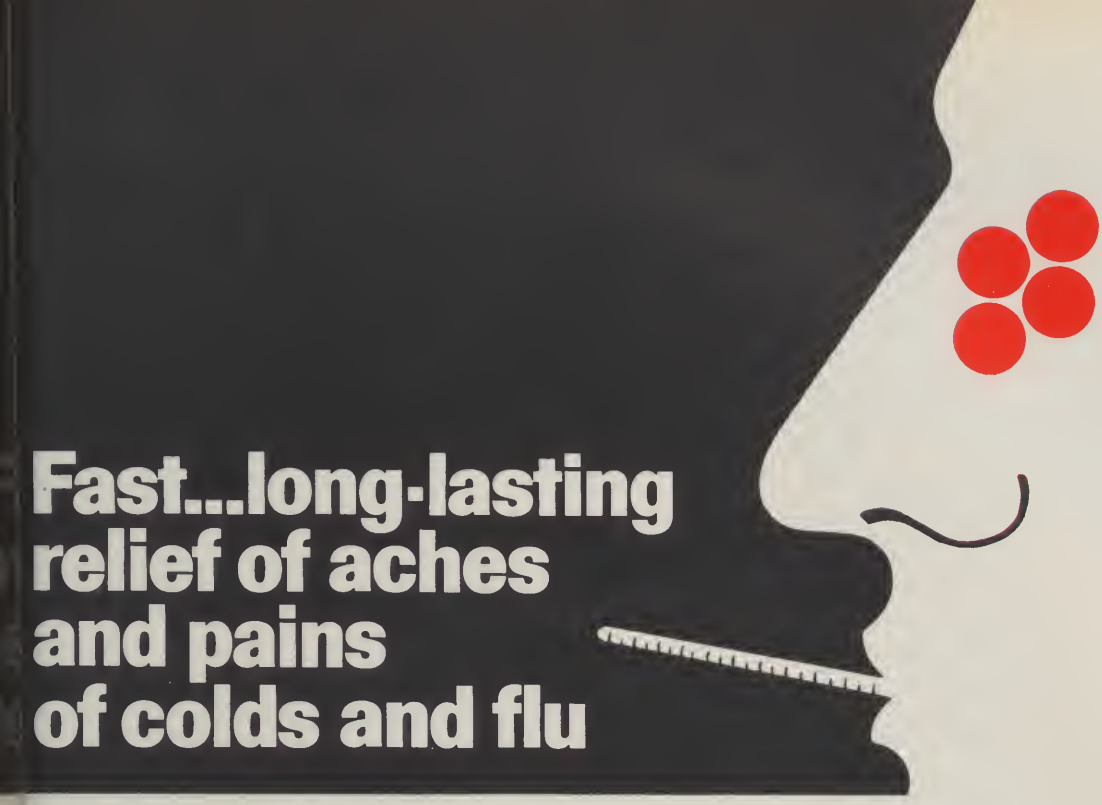

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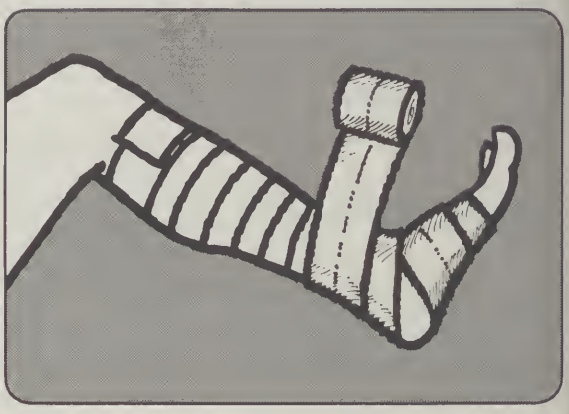

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INDICATION: Relief of insomnia of varied etiology.
CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.
WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.
Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.
Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.
PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.
ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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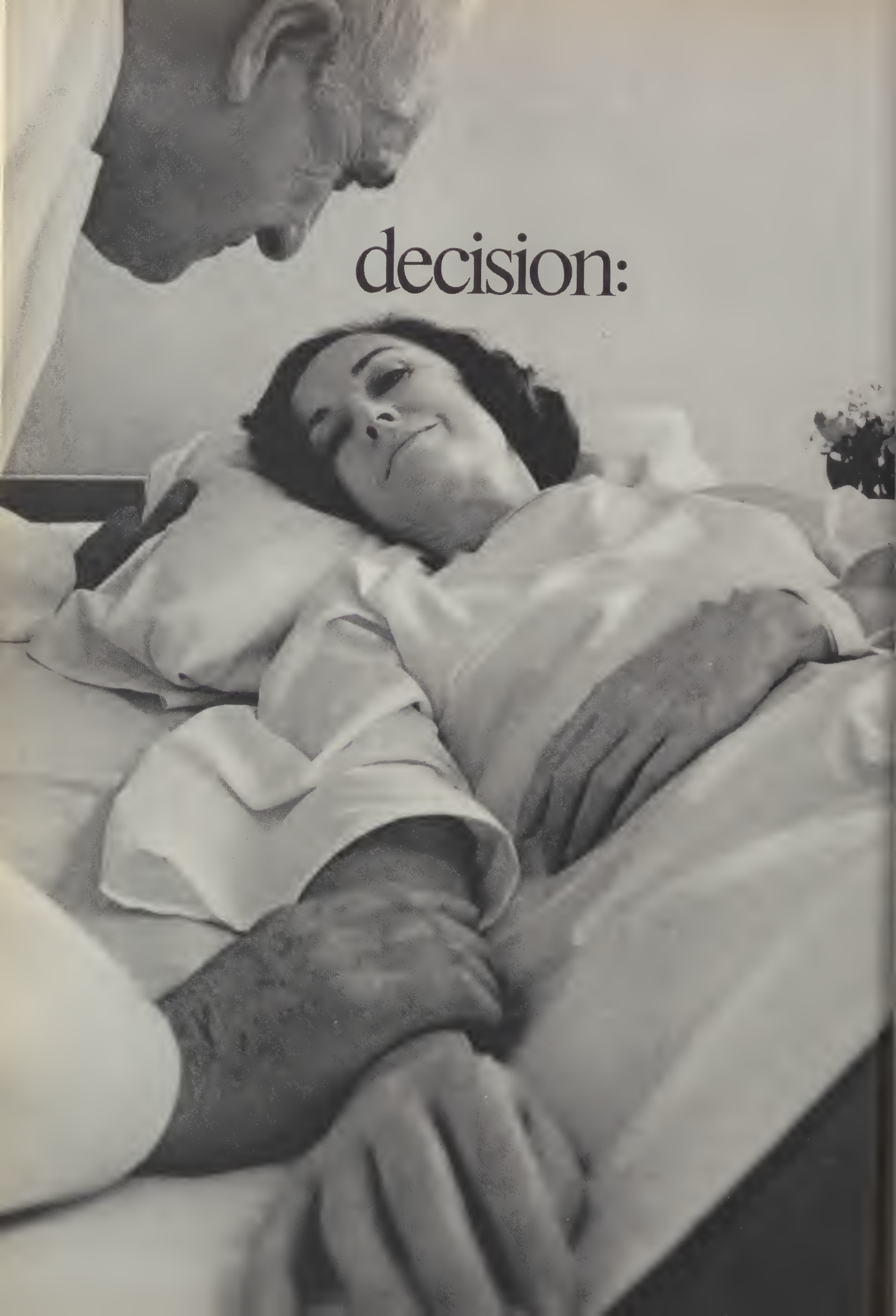
decision:

Loridine® I.M.
Cephaloridine

1.5 to 3 Gm. daily successfully treats many moderately severe infections*

- ctericidal action in vitro against sceptible organisms causing:
  - neumonia
  - inary tract infections
  - pticemia
  - scesses
- load-spectrum activity
- latively painless I.M. injection

ce to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

Lilly 000903

Loridine® CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Loridine®
CEPHALORIDINE

Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169]

Additional information available upon request.

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Lilly

0009

m.d.'s in the news

Eugene P. Pendergrass, M.D., emeritus chairman of the department of radiology at the Hospital of the University of Pennsylvania, has been named chairman of the Department of Health, Education and Welfare's (HEW) Council on Health and Safety. The appointment came from HEW Secretary Elliot Richardson. Dr. Pendergrass received the PMS Distinguished Service Award last October.

Donald Berkowitz, M.D., clinical associate of medicine at Temple University School of Medicine, has been elected to the board of trustees of the American College of Gastroenterology. Dr. Berkowitz is also an attending physician in gastroenterology at the Albert Einstein Medical Center in Philadelphia.

Alexander Minno, M.D., of Pittsburgh, recently served as chairman of the American Society of Internal Medicine's pharmaceutical committee meeting held in Miami, Fla. Earlier this year he conducted two medical pharmacy workshops as part of the University of California, San Francisco Branch's continuing education program.

James A. Shaver, M.D., has been appointed associate professor of medicine at the University of Pittsburgh School of Medicine. Dr. Shaver is also the director of the cardiac diagnostic laboratories of the Presbyterian-University Hospital and chairman of the research committee for the Western Pennsylvania Heart Association.

Herbert C. Mansmann, M.D., has been appointed medical director of the Children's Heart Hospital in Philadelphia. Dr. Mansmann is associate professor of medicine at Jefferson Medical College, director of Immunological Allergy Research Division of the medical college and director of the Pediatric Clinic at Jefferson. He has also served as president of the Pennsylvania Allergy Association and is well known for his work in pediatric allergy and immunology.

George C. Griffith, M.D., a cardiologist and former member of the staff of the Presbyterian-University of Pennsylvania Medical Center in Philadelphia was honored at the center's annual meeting. Dr. Griffith received the Saunders Award from Paul J. Cupp, president of the board of trustees, and Richard H. Helfant, M.D., the newly appointed chief of cardiology at the center.

Mayer A. Green, M.D., Pittsburgh, served as an official representative of the AMA to the Seventh International Congress of Allergy in Florence, Italy. During the groups scientific session Dr. Green presented a paper entitled "Heads Up Approach to the Treatment of Status Asthmaticus," which he co-authored with Richard L. Green, M.D.

A semi-annual lecture program honoring James Z. Appel, M.D., a Lancaster physician who served as president of the AMA in 1965-66, has been established by the staff of the Lancaster General Hospital. The first lecture was given in November by Dana Farnsworth, M.D., director of University Health Services at Harvard University.

Thomas H. Ainsworth, Jr., M.D., Bryn Mawr, was recently named associate director of the American Hospital Association and chairman of the association's committee on physicians.

Garfield G. Duncan, M.D., a world-famous authority on diabetes with a lengthy affiliation with the Pennsylvania Hospital in Philadelphia, recently donated a complete set of the twenty books he had published during his career to the hospital's library. Although Dr. Duncan officially retired from the directorship of the division of medicine and head of the department on metabolism and nutrition, he has continued to serve the hospital as a consulting physician.

Among recent appointments at Jefferson Medical College are Gordon F. Schwartz, M.D., as assistant professor of surgery at Jefferson and director of the surgical training program at the college's hospital; Diron O. Mikaelian, M.D., assistant professor of otolaryngology, and Gordon P. Holt, M.D., as assistant professor of otolaryngology.

J. Joseph Danyo, M.D., a York Hospital orthopedic surgeon, has been elected the first president of the newly-formed American Association for Hand Surgery. The association, based in Detroit, Mich., will hold its first meeting in Montreal, Canada this year. Dr. Danyo is also president of the Detroit-based J. L. Posch Hand Society.

Christian M. Hansen, Jr., M.D., New Hope, was honored by Haverford College when he was named as a recipient of the 1970 Haverford Award. The award is presented annually to alumni who best reflect the college's stated concern that knowledge be applied to socially useful ends. At present Dr. Hansen is director of child health services at the Trenton Neighborhood Family Health Center.

Charles S. Cameron, M.D., president of Hahnemann Medical College and Hospital, received the Clement Cleveland Award for his dedicated service to the cause of cancer control. Dr. Cameron is the author of the best seller *The Truth About Cancer.*

SARA H. SMALL accepts the Franklin County Centenarian Award from Herman A. Gilda, M.D., her family physician. Also in attendance are (center) Joseph O. Strite, M.D., president of the Franklin County Medical Society, and (right) John P. Manges, M.D., secretary of the society.

A. Richard Kendall, M.D. and **Lester Karafin, M.D.,** Philadelphia physicians and recipients of the 1970 Christian R. and Mary F. Lindback Award for distinguished teaching in the clinical sciences at Medical College of Pennsylvania, have donated their $1,000 award money toward the establishment of a new stoma clinic at MCP. Dr. Karafin, professor of urology and head of the section, and Dr. Kendall, clinical associate professor of urology, estimate that there are thousands of patients in need of this type of service.

S. Philip Bralow, M.D., Philadelphia, professor of medicine at Jefferson Medical College and guest speaker at the recent Southern District Medical Association of Puerto Rico's annual convention, was named an honorary member of the association. During the convention Dr. Bralow discussed hepatitis and gastric cancer, participated in a panel on shock, and served as a consultant at the scientific sessions.

DR. COON

DR. COURSIN

Two Pennsylvania physicians, **J. M. Coon, M.D.,** Philadelphia, and **David B. Coursin, M.D.,** Lancaster, have had articles published recently in *Modern Medicine*. Dr. Coon, who authored "Food Toxicology: Safety of Food Additives," is the chairman of the department of pharmacology at Jefferson Medical College. "Relationship of Nutrition to Mental Growth and Development" was the article written by Dr. Coursin, who is presently the director of the Research Institute at St. Joseph Hospital in Lancaster.

Joseph J. Sandler, M.D., British psychoanalyst and an associate of Anna Freud, has been appointed a visiting professor in psychoanalysis at Medical College of Pennsylvania. Among his published works is the book *Toward A Basic Psychoanalytic Model*, published in 1969. Dr. Sandler will speak twice each year in Philadelphia and participate in conferences and teaching programs for medical students, residents and faculty.

David S. Smith, M.D., director of the division of inpatient services at St. Christopher's Hospital for Children, Philadelphia, has been elected the president of the Philadelphia Pediatric Society for 1971. The society, now seventy-five years old, is the nation's oldest pediatric society. Dr. Smith also holds a professorship at Temple University School of Medicine.

Among the recent appointments at the University of Pittsburgh School of Medicine are: **John Hitchcock, M.D.,** now associate professor of psychiatry; **Benito Lombardi, M.D.,** professor of pathology; **Patricia Anne Hoffee, M.D.,** associate professor of microbiology; and **Niel Wald, M.D.,** chairman of the department of radiation health at Pitt's Graduate School of Public Health.

The Urological Association of Pennsylvania, Inc. has announced its 1971 officers. **Robert H. Bradley, M.D.,** Philadelphia, has been named president; **Marshall U. Rumbaugh, M.D.,** Kingston, was elected president-elect; and **Josiah F. Reed, Jr., M.D.,** Harrisburg, was elected secretary-treasurer.

Carmela F. de Rivas, M.D., formerly director of the Norristown State Hospital, has joined the staff of the Penn Foundation for Mental Health at Sellersville. She will act as staff psychiatrist for the foundation. Dr. de Rivas recently was appointed a member of the medical assistance advisory council of the Department of Public Welfare. She is a member of the PMS Commission on Mental Health/Mental Retardation.

Vincent G. Hawkey, M.D., Meadville, was honored at a recent Crawford County Medical Society meeting. Dr. Hawkey, a private practitioner and surgeon, was presented with a plaque in recognition of his fifty years of service in medicine. **William A. Limberger, M.D.,** president of the PMS made the presentation.

More than 100 radiologists from around the world gathered recently t honor their teacher, **Eugene P. Pendergrass, M.D.,** emeritus professor c radiology at the University of Pennsyl vania. The members of the Associatio of Pendergrass Fellows, founded i 1920 by and for residents who studie with Dr. Pendergrass, celebrated Dr Pendergrass seventy-fifth birthday which he had marked October 6 whe he received the PMS Distinguishe Service Award.

Paul S. Porter, M.D., Mt. Lebanon was elected president-elect of th newly formed Dermatology-Genetic Society. The society is an internationa organization of physicians and special ists interested in genetic disease effect upon the skin. Dr. Porter is head o the dermatology section of the Fall Clinic, operated by the Presbyterian University Hospital in Pittsburgh.

Charles E. Hartman, M.D., Glen Rock, is York County's new coroner He succeeds H. Malcolm Read, who died late last year. The appointment made by the former Governor Raymond P. Shafer, expires in 1973.

Two new section heads have been named by Pennsylvania Hospital **Peter F. Binnion, M.D.,** was named head of the section of cardiology and **Richard H. Rothman, M.D.,** was made head of the section of Orthopedic Surgery. At this time Dr. Binnion was named an associate professor and Dr. Rothman an assistant professor at the University of Pennsylvania School of Medicine.

Leonard Bachman, M.D., director of the division of anesthesiology at the Children's Hospital of Philadelphia, has been elected chairman of the committee of anesthesiology of the American Academy of Pediatrics. Dr. Bachman is also a professor of anesthesiology at the University of Pennsylvania School of Medicine.

William N. Mebane, M.D., Philadelphia, a pediatrician and member of the board of managers of the St. Christopher's Hospital for Children, has been named chairman of the Pennsylvania Chapter of the American Academy of Pediatrics. His term extends through 1973.

IRS Rules Affect M.D.'s, Insurance Companies

New Internal Revenue Service regulations affecting physicians and insurance companies have been in force since January 1 of this year and not-so-quiet epithets from the companies are spreading across the land.

The regulations require insurance companies to report payments made to "health care providers" directly to the Internal Revenue Service.

The regulation was established to reduce the number of "health care providers" who fail to report as income all such monies they receive. A Treasury Department survey last year disclosed that such reporting failures may have taken place with about one-tenth of one per cent of the physicians in the nation — a record that any other segment of the population could envy.

That was the goal. But the result has been increased insurance costs because of the massive amount of record keeping the regulation forces on insurance companies and government program fiscal agents.

More Paper Work

The regulation requires physicians "under penalty of law" (a $5.00 fine for each instance) to furnish the insurance companies or fiscal agent with their taxpayer identification number which usually is the Social Security number or, if it is different, the employee identification number assigned by the IRS.

Thus, Pennsylvania physicians are finding claim forms and payment drafts rubber stamped with a notice that is similar to this one:

"Attention medical provider. Under Section 6401 in Revenue Ruling 69-595 we are required to report certain payments to doctors and other medical providers. Under Section 6109 we are required to request and you are required under penalty of law to furnish your taxpayer identification number, either your employee identification number or your Social Security number."

By way of explanation, the ruling mentioned directs that any payments made to health care providers under health, accident and sickness insurance plans, or under medical assistance programs which were assigned by the insured and paid directly to the supplier, are to be reported by the payor to the Internal Revenue Service.

Federal Programs Included

In the case of federally supported health programs such as Medicare, Medicaid and the Federal Employees' Health Insurance Program, the ruling applies to both direct—assigned—claims and indirect—unassigned—claims. With private insurance policies and health plans, the ruling requires filing only with respect to payments made directly or jointly to the provider.

Only payments totaling $600 or more during a calendar year need be reported by the firms but in order to make that determination, they have been forced to keep records of all payments and to identify all payments with the taxpayer identification number of the recipients.

The ruling identifies health care providers as any one delivering personal health care service to an individual. This includes physicians, dentists, nurses, special medical clinics, professional associations, proprietary hospitals, extended care facilities, home health agencies, etc.

SHOWN ABOVE: New officers for 1971 installed at a recent meeting of the Delaware County Medical Society are (left to right) Past President Conrad A. Etzel, M.D., Secretary Hunter S. Neal, M.D., President-Elect Otto F. Muller, M.D., President John H. Wigton, M.D., Vice-President David L. Mudrick, M.D., and Treasurer Philip J. Esgro, M.D. At the right, PMS President William A. Limberger, M.D. (left) presents the PMS Fifty Year Award to Ferdinand W. Nyemetz, M.D. of Media (right).

Dr. Blain To Lead Education, Research

New Superintendent At Byberry

Franklyn R. Clarke, M.D., has been appointed superintendent of Philadelphia State Hospital (PSH) at Byberry, the state's largest psychiatric facility.

Dr. Clarke, who has been assistant superintendent in charge of patient care at PSH since 1966, succeeds Daniel Blain, M.D. He is, at 44, one of the youngest men to head a Commonwealth hospital and the first staff member of Byberry to be appointed its superintendent.

Dr. Blain, director of Philadelphia State Hospital at Byberry since 1966, moves to a newly created post as assistant superintendent for research and education.

Menninger trained, Dr. Clarke completed his psychiatric residency at the famed Topeka, Kansas, clinic and is the only Commonwealth-employed psychiatrist to graduate from there. He has been a prime mover behind PSH's decentralized move to the unit system, which has divided Byberry into a series of semi-autonomous hospitals, each serving people from specific areas of the city and lower Bucks County, and each working with community agencies to develop aftercare programs.

In accepting his appointment, Dr. Clarke outlined these plans:

1. An open door policy on more patient wards and buildings.

2. A wipeout of the last vestiges of patient peonage.

3. A continuing change in the hospital's role to a transient, psychiatric treatment facility which brings patients to the point where they can receive long-term therapy at their community mental health centers.

4. Reduction in the patient census to 1,100.

5. Recruitment of top-level people with the skills essential to team treatment rather than custodial care.

6. A full-time treatment program, seven days a week, evenings and weekends, for every patient in the hospital.

Dr. Clarke called for modifying staff attitudes with a basic belief that every patient can be helped. "We have posted a patient Bill of Rights in every ward in our hospital," he declared. "We have guaranteed him his civil rights as a patient, but nowhere have we guaranteed that we will accord him the same dignity as an adult human being which we accord to people who do not have a mental illness."

Dr. Clarke has risen steadily through a variety of positions at Philadelphia State Hospital since 1960 when he came to Byberry as a staff psychiatrist. He became clinical director of an intensive treatment unit from 1962 to 1964, and director of professional education from 1964 to

DR. CLARKE

1966. As assistant superintendent, Dr. Clarke was responsible for the design and implementation of Byberry's dramatic patient reduction from more than 6,000 to 2,500 residents. In the same post he brought together therapeutic specialists in dance, art, and drama for a new creative arts therapy department. Under his leadership, PSH has reorganized its vocational adjustment services to provide job testing, counseling, and training to aid in returning patients to community life.

Originally trained as a clinical psychologist—he earned his bachelor's and master's degrees in the field from Penn State University in 1949 and 1950, respectively; he received his medical training at Jefferson Medical College. From 1944 to 1947 he served as a lieutenant in the U.S. Maritime Service, and from 1958 to 1960 he was assigned by the Navy to the Psychiatric Observation Unit at the Marine Corps Recruit Training Depot, Paris Island, S.C.

Dr. Clarke is a diplomate of th American Board of Psychiatry an Neurology and assistant professor o clinical psychiatry at Thomas Jef ferson University. He serves on th boards of the Lutheran Children' Bureau and the Bucks County Psychia tric Center. He is active in the Menta Health Association of Southeaster Pennsylvania.

Dr. Blain, who is given major credit for changing Byberry from a custodial into a rehabilitative facility, will work on a part-time basis.

"Placing research and education on an equal status with clinical and administrative services moves us closer toward our stated goals of involving all hospital personnel in some form of continuing education and including everyone in a hospital-wide curiosity quest which could lead to studies, surveys and research projects," he said.

Dr. Blain described PSH's department of education as being in the vanguard of state hospitals for its extensive training for all levels of staff, from psychiatric aides to psychiatric residents. Among almost fifty courses are high school equivalency classes for patients and staff, university graduate and undergraduate credit courses, training for activities therapists, orientation of new employees, as well as courses for supervisory personnel and mental health workers.

Plans include the expansion of existing programs with area medical schools, schools of nursing, departments of clinical psychology, anthropology and sociology. These will be accompanied by increased field service training of social workers, psychologists and other professionals, Dr. Blain explained.

"As a leading training center for mental health and mental retardation personnel, we will continue to find more effective use of manpower," he declared. "An example is our psychiatric training for student nurses, where affiliated schools supply their own faculty and our pioneer mental health worker training program for college graduates."

Shock-Trauma Unit Opens At Hahnemann

Traumatic injury from highway, ome and industrial accidents, fire, ivil disorder, and violence is increasng at an alarming rate. The wide specrum of accidental, combat-like injuies, such as burns, concussions, fracures, shock, gunshot and knife vounds, come under the broad categoy of trauma. However, there is no nedical specialty devoted exclusively o the study and treatment of trauma.

A prototype patient service, the new ietty and Milton Kroungold Shockrauma Unit, at the Hahnemann Medcal College and Hospital of Philadelhia is a model of multidisciplinary are of shock and trauma patients. The nit and its supporting laboratories ost in excess of $250,000.

This five-bed unit is supported by a ore laboratory directly adjacent to the nit, and a critical care laboratory vhich will function around the clock to provide vital information for the maintenance of life under conditions of trauma and shock.

On a regional basis, the staff of the Kroungold Shock Trauma Unit will serve as consultants to surgeons and physicians who treat severely injured patients in area hospitals. "The first purpose of the unit and its supporting laboratories," according to Charles C. Wolferth, M.D., professor and chairman of the department of surgery, "is to deliver the needed medical care swiftly and efficiently to severely injured patients. In addition, we hope to conduct studies of the specific problems associated with shock and trauma to add new knowledge to the pathophysiology of the injured. Education and rehabilitation are inherent in the program," Dr. Wolferth explained. "We plan to train medical and paramedical personnel in the care of shock and trauma patients, and establish a dynamic rehabilitation program. The final objective," he noted, "is to educate the public about trauma prevention and first aid, and to inform the public of the need for this type of unit in their home communities."

All emergency patients are seen in the emergency room first. Those whose diagnosis of shock and trauma are verified will be transferred to the special unit after emergency resuscitative treatment. They will remain in the shock trauma unit during the most critical part of their recovery. Then they will be transferred to the general hospital area. A mobile team from the shock trauma unit will follow the patient throughout his hospitalization. If surgery is required, the patient will return to the unit for the immediate post-operative period.

New Film Shows Uses of Lasers

The clinical application of one of he wonders of modern science — the aser light beam — is demonstrated in new medical film starring a trio of cientific specialists.

Produced by The Upjohn Company, Kalamazoo, the film shows how expert ands can use lasers with startling effectiveness in procedures ranging from revention of blindness in diabetics to emoval of brain tumors, and even kin tattoos.

The cast includes a neurosurgeon, an ophthalmologist and a dermatologist, each illustrating the versatility of asers with respect to his own specialty. They show how the microscopic, intensely hot light beams can be controlled to slice through soft tissue with little or no loss of blood.

The 19-minute film, titled "Clinical Applications of Lasers," was produced as a professional service by Upjohn for viewing by audiences in the medical fields. The 16 mm. film is available on a temporary free-loan basis. Requests for prints, listing alternate dates, should be addressed to Upjohn Professional Film Library, 7000 Portage Road, Kalamazoo, Mich. 49001.

Council Assigns Study

PMS Council on Public Service has appointed a special committee to study the details involved in participation in the Philadelphia Bicentennial. The members are: James B. Donaldson, M.D., Philadelphia; H. Robert Davis, M.D., Boiling Springs; Wilson Everhart, M.D., Harrisburg; and Joseph Ichter, M.D., Doylestown.

A LUNCHEON RECESS at a recent meeting of the PMS Committee on Objectives found members enjoying a buffet at the Society's headquarters building. Shown above (left to right) are George S. Klump, M.D., Williamsport; PMS President William A. Limberger, M.D.; and Committee on Objectives Chairman Wilbur E. Flannery, M.D.

Liability For Post-Transfusion Hepatitis

ANTHONY E. MAAS, M.D., ASSOCIATE DIRECTOR
Division of Laboratories, Harrisburg Polyclinic Hospital
Harrisburg

Hospitals and blood banks across the nation were shocked recently by two court rulings (Cunningham vs. MacNeal Memorial Hospital, Illinois Supreme Court, September 29, 1970, and Hoffman vs. Misericordia Hospital of Philadelphia, 267 A 2d 867, 1970*) in liability cases against community hospitals for post-transfusion hepatitis. In both cases the courts held that the hospitals were liable even though they might have done everything possible to preclude the existence of the hepatitis virus in the transfused blood.

This strict application of the liability laws in product litigation to transfused blood is sure to raise the indignation of many who potentially are defendants in similar suits, and it will no doubt give rise to concerted legal action by hospitals and medical societies in many states to prevent future actions on the part of claimants on the basis of these two precedents. The hospitals and blood banks rightfully contend that blood is not a product for sale, but a service. It is unfortunate that the practices of commercial blood banks, which purchase blood from professional donors to sell to customer hospitals at a profit, suggest to the courts that blood can be considered a marketable product. However, the vast majority of blood banks in the nation are organized as a community service, and the donor receives no other recompense than credit for blood in his account in the event that he or a member of his family would ever need it. The price that the community or hospital blood banks charge the recipient for blood covers only the processing and administrative expenses.

Anyone who is familiar with the operation of a blood bank realizes the many steps that are involved in the processing of a unit of blood to insure, by currently available methods, the safety as well as the effectiveness of the blood for the duration of its shelf life. The blood bank was one of the first areas in the hospital laboratory where rigid quality control standards were applied; and, of course, the more elaborate the control procedures, the higher the cost to the recipient. The service aspect of the blood bank requires that the bank have available at all times an adequate supply of blood of various types to meet demands around the clock, and the limited shelf life of bank blood represents a built-in loss factor further raising the costs of operation.

Blood bankers as a group probably are more aware than most individuals working in the hospital environment of the possibility of a law suit in the event that undesirable effects result from the transfusion of blood. The administrative and laboratory setup currently required for approval of a blood bank by the American Association of Blood Banks is designed to give a wide margin of safety for blood transfusion therapy.

The strict liability rule applied to blood as a product will certainly give rise to considerable anguish and uncertainty in workers in this specialty, particularly because there is no foolproof way to determine whether a unit of blood does contain the virus: a fact which the Illinois Supreme Court did not consider a valid defense. It is to the credit of the nation's hospitals, blood transfusion therapists, and technical staff that, in spite of these recent rulings, they have continued to provide this essential service in modern hospital practice without diminution.

The Pennsylvania Medical Society, in accordance with action taken by the Board of Trustees, will offer assistance to the defendants when the appeal of the Philadelphia case is heard before a higher court, and will enter the case as *amicus curiae* at the appropriate time.

It does not require a great deal of imagination to realize what conditions would exist in our hospitals without the ubiquitous availability of safe and reliable blood transfusions. Many lives would be lost. Many individuals with chronic hematological disorders could not be kept alive. Many patients could not qualify for lifesaving operations which they now can undergo with relative safety. Some surgical procedures would have to be discontinued altogether. There is, of course, no turning back from the practice of blood banking as it has developed over the years. The need for blood will probably continue to rise, particularly in view of the increasingly extensive use of blood component therapy and of the rising popularity of plasmapheresis for the re-

covery of essential blood clotting factors. What has to happen, of course, is that the medical and the legal professions will have to join to resolve the semantic and philosophical differences that currently exist.

The development of a reasonable compromise might find its expression in the enlightened opinion of a higher court in an actual litigation, or in legislation that is acceptable to the hospitals and to the medical profession. It is of the utmost importance that hastily conceived legislation to bar the bringing of suit in cases of this type be avoided: It has to be recognized at the outset that the matter of liability for transfusion-related hepatitis presents a problem, the solution of which requires careful consideration of all possible angles by both medical and legal experts. The liability problem is not limited to blood transfusions. It might conceivably be extended to donor organs such as kidneys or skin grafts. Clearly this is an area which is not adequately covered by existing law.

The courts, in recent years, have had the tendency to decide in favor of those suffering the adverse consequences of medical actions designed to help the patient, and against those who unwittingly may be the proximate cause for injury to him. The legal philosophy behind this is that the patient or his relatives have nowhere to turn for compensation for the injuries suffered. The dilemma in which we find ourselves arises in part out of our inability to control all factors that come into play in the therapeutic intervention, although many of the risks involved can be rather precisely calculated. It is clear that if the above-named legal precedents stand in higher courts, the medical profession and the hospitals will have to protect themselves with huge liability policies against similar suits, provided they can find the casualty companies to underwrite these liabilities.

At present the medical malpractice and liability fields are regarded as unprofitable by many insurance underwriters due to the huge awards by the courts to plaintiffs in successful liability suits. The resulting increased costs of operation are sure to be passed on to the patient. We will then have come full circle: in the end the patients will pay the price for this insurance. Would it not be more logical for the recipient of the service to carry the insurance which would protect him against the financial consequences of uncontrollable, harmful results? Where there are always more receivers of the service than providers, the greater spread of the risk involved may make it practicable for the health insurance industry to provide such coverage in the form of an additional premium to be paid with hospitalization insurance. This would, of course, in no way affect the liability of the hospital and of the physician and his assistants in cases where adverse results from blood transfusions result from actions inconsistent with good medical practice or where the doctrine of *res ipsa loquitur* is clearly applicable.

There remains also the problem of determining in an individual case what constitutes post-transfusion hepatitis in the legal sense. The fact that the disease arises within the incubation period for serum hepatitis is in itself no proof that it is transfusion related. There is as yet no laboratory test to detect the virus in the blood except in a minority of donors or recipients.

As a result of the above-mentioned decisions, there is a danger that the practice of blood banking will be curtailed severely to the detriment of patients. This larger risk should be weighed against that of the recipient who may contact hepatitis. The refinement of immunochemical procedures which currently are used for the detection of Australia antigen may, in the near future, eliminate a significant percentage of hepatitis virus carriers from the donor pool, resulting in decrease, if not complete elimination of the problem.

A consensus of opinion in the matter of liability for post-transfusion hepatitis between the medical and the legal community is urgently needed. As C.P. Snow once said: "It is at the border zone between two different disciplines that real progress can be made." We are looking forward to these results.

Emergency Medical Care

Doctors Must Treat Weak Link

Surveys have proven definitely that a victim of an emergency has a four times better chance of survival if his emergency situation occurs in an urban rather than in a rural area. The geographical factor in this serious problem is obviously unavoidable and is also beyond manipulation. The Pennsylvania Medical Society through its Commission on Emergency Medical Services under the Council on Education and Science has worked for three years on a program to improve emergency room care throughout the state. Ultimately this program should put better hospital facilities and emergency care within much easier reach of the widely disseminated population of all our rural communities.

Our attention must then turn to the remaining weak link in Emergency Medical Services . . . ambulance services. The quality of training and equipment, the quantity of ambulance services and their strategic locations are so variable throughout the state that two surveys have revealed that ambulance services range from very good to more dangerous than no service at all. One survey was conducted by the Department of Health with the stimulus of the National Highway Safety Act of 1966 which has a basic requirement for each state to establish adequate emergency care programs. To this end a sum of money has been allotted on a matching basis for upgrading certain local services which have qualified for such assistance.

The Pennsylvania Ambulance Association with the encouragement and assistance of the Pennsylvania Trauma Committee of the American College of Surgeons has conducted another survey on a more personal contact basis. This second survey looked deeper into significant details such as: (1) The quality and frequency of training programs for attendants; (2) The number of ambulances and rescue trucks including evaluation of the equipment in use; (3) Special consideration to communications which is important to coordinate services with the firemen, the police, and the emergency rooms, and to facilitate dispatching and to prevent overlap of coverage and (4) The need to pinpoint the areas of minimal or total lack of coverage.

The migrating population of today tends to scrutinize any new community on the basis of what they consider the "right" to have adequate ambulance services just as it scrutinizes the school system, the local hospital, the fire and police protection. The National Highway Safety Act of 1966 has made this "right" a matter that must be dealt with and has given it Federal Government status. Consequently there must now be complete community involvement, and no one is more capable or more duty-bound than the physician to lead the unification of the involvement of the hospitals, the ambulances, the local administration, the fire-police organizations, and the members of the community in general.

The proper and obviously easiest starting point for such programs in your own community is through an Emergency Medical Services Committee of your county medical society. Assistance in any programs may be obtained through the headquarters of the Pennsylvania Medical Society by directing inquiry to the Commission on Emergency Medical Services of the Council on Education and Science.

Frank H. Ridgley, M.D.
Commission on Emergency Medical Services

Licorice Intoxication

Licorice intoxication as a cause of metabolic alkalosis and hypokalemia appears in this issue of PENNSYLVANIA MEDICINE. The hyperaldosterone-like clinical picture produced by excessive licorice ingestion is striking. One cannot help but get the feeling that, when the cause of the intoxication in the current case reported by Robinson et al. is considered, even more cases will be discovered. Substituting food and candy by people giving up the cigarette habit is a commonly used way to try and cope with the urge to smoke. The potential serious consequences of licorice intoxication and the use of licorice as an oral substitute for smoking should alert the practicing physician to this hazard. The emphasis by Robinson et al. on the seriousness of hypokalemia is well deserved particularly in pointing out its detrimental effects on cardiac rhythm and renal function. The need for public and physician awareness to licorice intoxication is self-evident.

DAS

Let George Say It

Rural Groups and Young Doctors

GEORGE A. ROWLAND, M.D.
Millville

Private solo practice has lost much of its charm to new doctors entering the field in America today. There are many reasons why this is so. In the first place, there are the increasing attractive alternatives with hospitalization, pension plans, and paid vacations. Add to this the fact that governmental agencies are ever putting more obstacles in the path of the private practitioner. Paper work alone requires that he start out with at least one full-time employee. Many of the advantages of salaried practice are denied him entirely unless he takes the lengthy and expensive path toward incorporation.

The greatest deterrent to private practice still is the natural disinclination to unnecessary work. Starting a practice involves time and effort. It is necessary to find an office, buy equipment, hire help, establish hospital relations, and care for 10,000 details. On the other hand, a job interview, if satisfactory, completes all the pre-employment arrangements and the young man fresh out of a residency can walk into an already prepared office and start seeing patients the first thing Monday morning.

With literally thousands of salaried positions open to medical graduates, it is surprising that there are still a few hardy souls ready to go into business for themselves. They are not too numerous. I would like to see figures on how many new practices have been initiated in Pennsylvania in each of the last ten years. I suspect that the curve would show a marked diminution. Unfortunately, many of the men going into salaried practice are not applying their medical degree to the care of patients. Many positions in government, administration, industry and teaching are remote from patient care.

In other parts of this nation, medical groups have proliferated and these regularly advertise attractive openings for suitably prepared men. Such offerings present to the young doctor the opportunity to practice medicine and care for patients, the simplicity of entering an already established practice, and usually a chance for advancement to a full partnership in a few years. Although there is evidence that such arrangements are increasing in Pennsylvania, they are still few in number, especially in the physician-poor rural areas.

Many efforts have been and are being made to induce young doctors to enter rural practice. Group medicine could increase the attraction. Solo physicians should make the effort to take on associates. Partnerships and groups already in existence should arrange to open their rosters and make the facts known. It will not immediately solve the problem of maldistribution of medical care but it will be a step in the right direction. The few doctors who still have the fortitutde to establish themselves in private practice will always do so. Some of the others may be lured into the boondocks if easy, comfortable employment is more available.

Thoughts On The Legalization Of Abortion

Abortion, as a surgical method of family planning, is as economically unsound as it is inevitable.

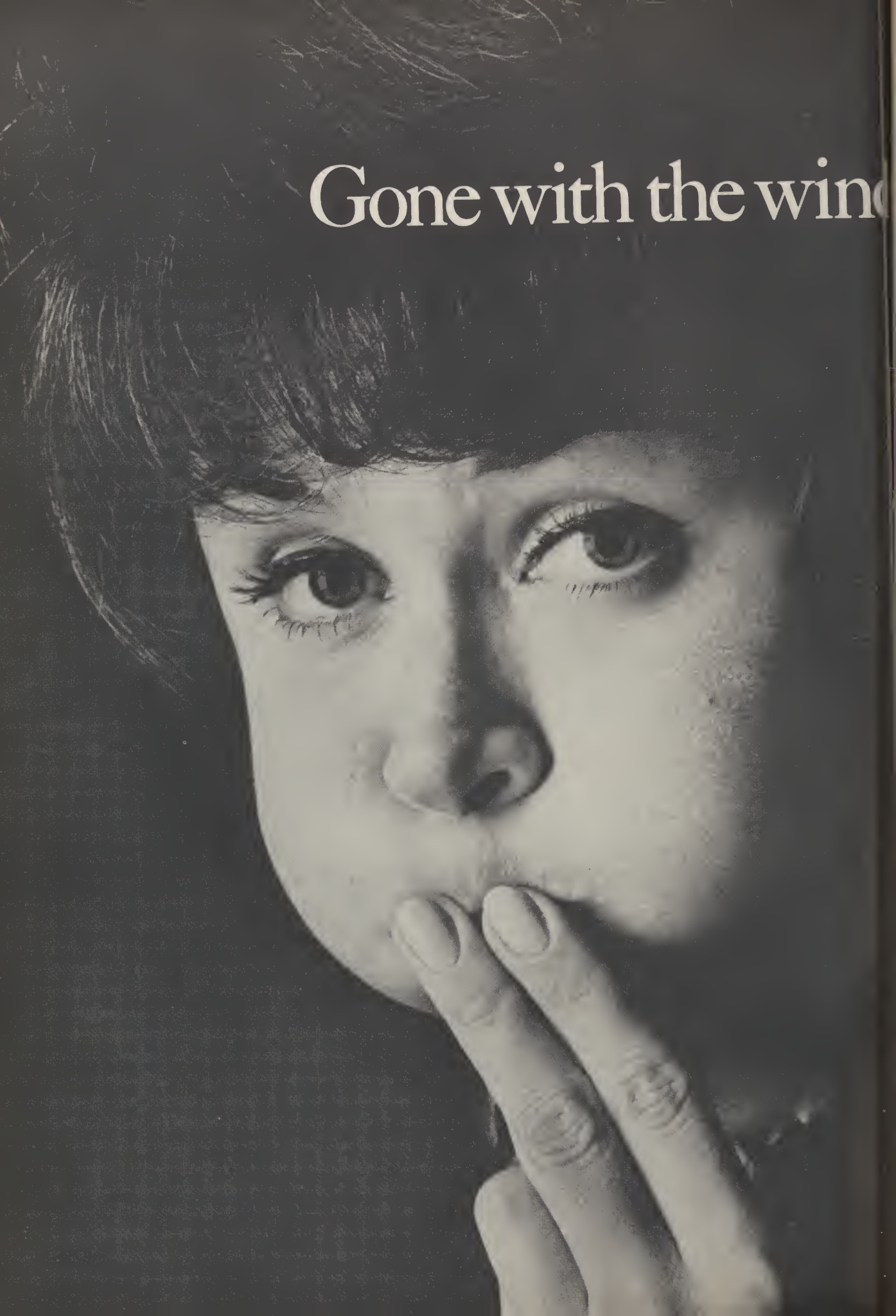
The demographers point out to us that in every country where abortion on demand is law, abortion has become the principal method of population control. Japan is an excellent example with one termination of pregnancy recorded for every two live births. The majority of women in their reproductive years are capable of achieving one pregnancy a year. Currently an "in hospital" termination costs a minimum of $500. Prevention of that pregnancy by the most effective but most controversial method available today cannot possibly cost more than $50 a year. From strictly an economic point of view abortion as a method of family planning appears to be irresponsible.

From the standpoint of safety, if one looks at the figures covering morbidity and mortality from an institution such as Johns Hopkins Hospital, there can be no question that first trimester abortion is much safer than carrying any pregnancy to term and experiencing labor and delivery. Again it would seem that improving patient care in an effort to reduce the risk involved in pregnancy, labor, and delivery would be more desirable than terminating a pregnancy.

On the other hand it occurs to me that only those who ascribe to the philosophy that "we may not interfere with life" after the moment of fertilization have any logical grounds to moralize about abortion, and certainly I agree that the "moralist" must worry about the life of a North Vietnamese as he worries about the fate of a six-week embryo if his argument is to be valid.

In the near future the right of a woman to decide not only if she should become pregnant but if she will remain pregnant will be established by the Supreme Court. Although I personally will be content if I never take part in another termination of pregnancy, it seems proper that we as physicians cease to afflict the population with our personal attitudes but instead, provide our patients with accurate information so they might make intelligent decisions regarding family planning, whether that decision involves the rhythm method, I.U.D.'s, oral contraception, or abortion. Abortion as a method of population control and family planning will soon be a reality and we would spend our time more wisely in trying to find the best way to provide this service to our patients rather than to debate our personal attitudes about the subject.

Gerald Malick, M.D.
The Medical Record
Berks County Medical Society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*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

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Folic acid	0.5 mg
Ascorbic acid (vitamin C)	500 mg

Description: For prophylactic or therapeutic nutritional supplementation concomitant with levodopa therapy in patients with Parkinson's disease and syndrome, Larobec provides high potency dosages of the major B-complex vitamins, without pyridoxine (vitamin B_6) which has been reported[1,2] to reduce the clinical benefits of levodopa therapy. B-complex vitamins are essential in the anabolism of carbohydrate and protein and in hematopoiesis. Larobec also contains therapeutic quantities of ascorbic acid, a substance involved in intracellular reactions such as tissue repair and collagen formation.
Indications: Larobec is indicated for supportive nutritional supplementation when a water-soluble vitamin formula (without pyridoxine) is required prophylactically or therapeutically in patients under treatment with levodopa.
Warning: Administration of vitamin B_6 may be required if signs of pyridoxine deficiency develop. Larobec is not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B_{12}.
Dosage and Administration: One or two tablets daily, as indicated by clinical need.
How Supplied: Orange-colored, capsule-shaped tablets, imprinted Roche 73; bottles of 100.
References:
1. Duvoisin, R. C., *et al.*: *Trans. Amer. Neurol. Assoc., 94*:81, 1969. 2. Cotzias, G. C.: *J.A.M.A., 210*:1255, 1969.

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

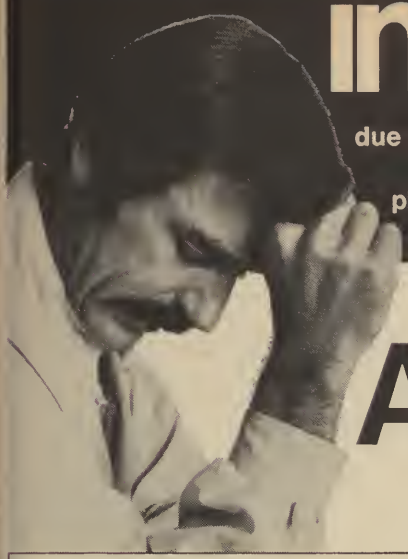
The treatment of

impotence

due to androgenic deficiency in the American male. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



Android®

(thyroid-androgen) tablets

Double-Blind Study and Type of Patient:
100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

REFER TO PDR

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dubiln, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25), Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

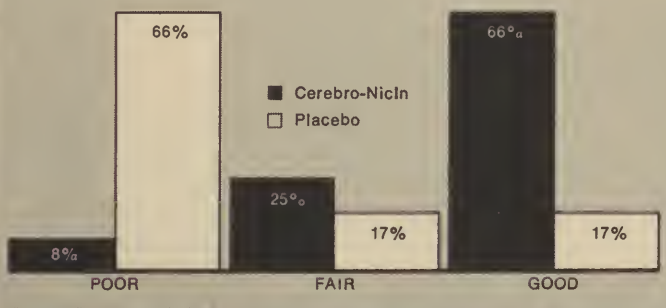
Write for literature and samples: BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West 6th Street, Los Angeles, California 90057

For the treatment of the aging patient

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
1-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir 8 oz. bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

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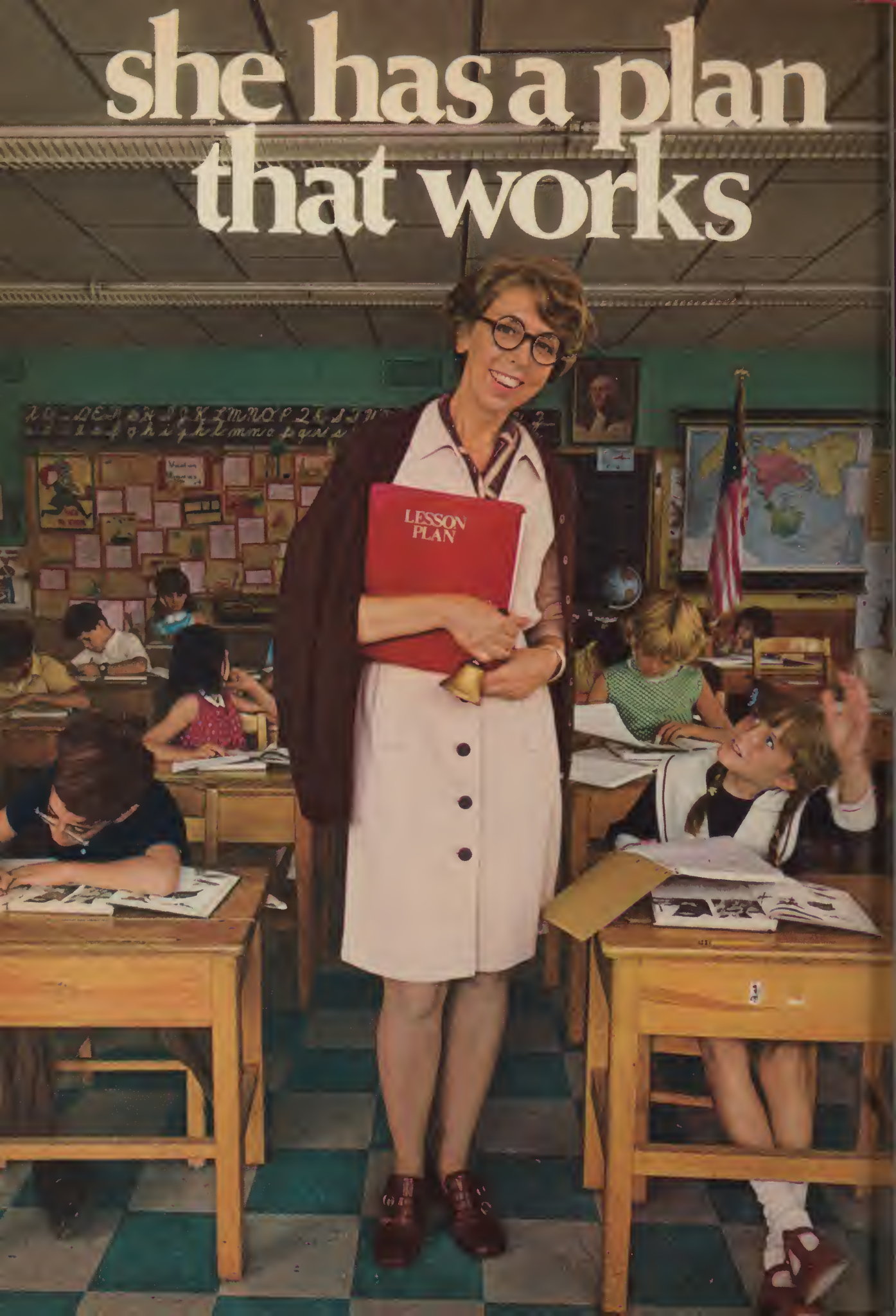
2500 W. 6th St., Los Angeles, Calif. 90057
Write for Product Catalog

she has a plan that works



She has a plan that works.

She has one plan for the class. And they really respond.

She has another plan just for herself. A medication plan for her hypertension. And she's also responding beautifully.

More than just another antihypertensive, Ser-Ap-Es can be a whole medication plan for living with hypertension.

Does it get good marks for comfort?

Excellent. Because Ser-Ap-Es controls blood pressure effectively, dosage of each component is lower than if prescribed alone, usually minimizing side effects. However, side effects may occur (see prescribing information).

Designed with the kidney in mind?

Hydralazine maintains or increases renal blood flow.

And the brain too?

Hydralazine also relaxes cerebral vascular tone. And reserpine has beneficial calming action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

Practical on a teacher's salary?

Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits…

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

C I B A

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

a plan for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

INDICATIONS: All cases of hypertension except the mildest and the most severe.

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

Hydralazine: Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Reserpine: The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydralazine: Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

Hydralazine: Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Reserpine: Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

Hydralazine: Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

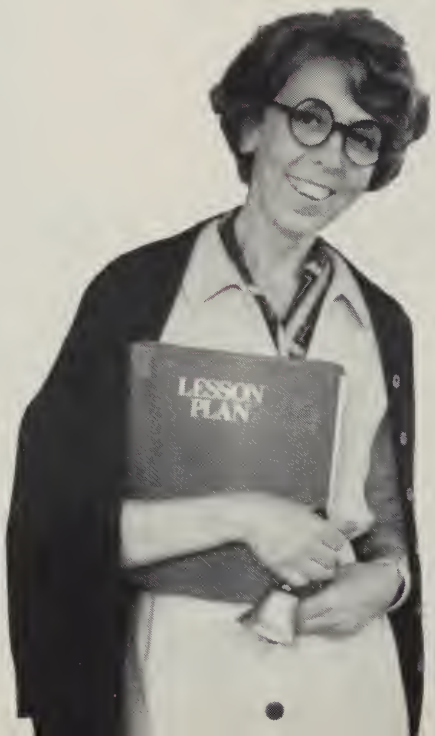
DOSAGE: One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

SUPPLIED: *Tablets* (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Summit, New Jersey

2/4623



she has a plan that works for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

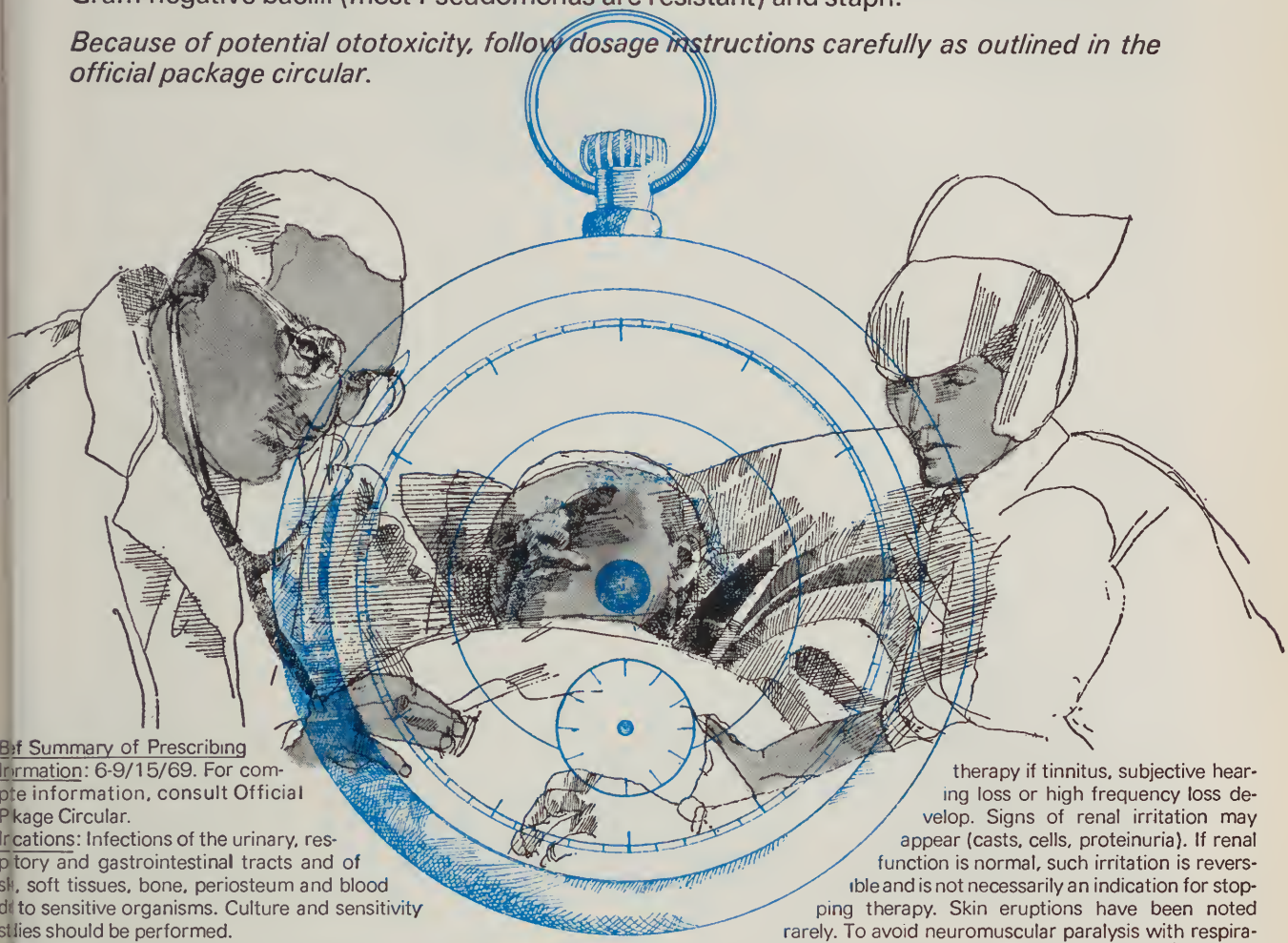
CIBA

A valuable hospital antibiotic —when there is no time

in severe systemic infections—postoperative bacteremia, Gram-negative/staph pneumonias or neonatal sepsis—Kantrex® (kanamycin sulfate) is often indicated before results of customary sensitivity tests can be reported. Clinical response is often seen within 24-48 hours in susceptible infections, with remission soon after.

10 years of experience confirm the continuing effectiveness of Kantrex® against many Gram-negative bacilli (most Pseudomonas are resistant) and staph.

Because of potential ototoxicity, follow dosage instructions carefully as outlined in the official package circular.



Brief Summary of Prescribing Information: 6-9/15/69. For complete information, consult Official Package Circular.

Indications: Infections of the urinary, respiratory and gastrointestinal tracts and of skin, soft tissues, bone, periosteum and blood due to sensitive organisms. Culture and sensitivity studies should be performed.

Contraindications: A history of hypersensitivity to the drug. Prior auditory damage by kanamycin or other agents may be a contraindication if effective alternative therapy is available.

Warnings: Since the drug is excreted almost entirely by glomerular filtration, renal malfunction can cause abnormally high serum levels of kanamycin which may prove ototoxic. Assess renal function periodically, both before and during therapy. Renal dysfunction or pre-renal azotemia sharply increase the risk of ototoxicity and permanent deafness. In such cases decrease the size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. In older patients or patients receiving a total dose in excess of 15 Grams, watch carefully for signs of ototoxicity.

Precautions: If mycotic or bacterial superinfection occurs, discontinue kanamycin and initiate appropriate therapy. Cumulative ototoxic effects may be produced by concurrent or consecutive use of other ototoxic drugs. High doses may cause irritation at injection sites. The drug *should not* be physically mixed with other antimicrobials.

Adverse Reactions: Severe irreversible hearing loss may occur. Stop therapy if tinnitus, subjective hearing loss or high frequency loss develop. Signs of renal irritation may appear (casts, cells, proteinuria). If renal function is normal, such irritation is reversible and is not necessarily an indication for stopping therapy. Skin eruptions have been noted rarely. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in postoperative patients until recovery from anesthesia and muscle relaxants is complete.

Dosage and Administration: The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gram daily and should not exceed 1.5 Gram even in the heaviest patients. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours.

Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations: 0.5 Gm. in 2 ml. 1.0 Gm. in 3 ml.

Also available—Pediatric Injection 75 mg. in 2 ml.

A.H.F.S. Category 8:12.28

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Division of Bristol-Myers Company
Syracuse, New York 13201

KANTREX® INJECTION
(kanamycin sulfate)

Not too little, not too much... but just right!

"Just right" amounts of Ilosone Liquid 250 can be dispensed easily from the pint bottle in *any* quantity you specify to meet your patients' precise needs— without regard to package size.

ready-mixed

Ilosone® Liquid 250

Erythromycin Estolate

(equivalent to 250 mg. of base per 5-ml. teaspoonful)

Additional information available to the profession on request.
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Lilly

100204

Cardiac Abnormalities Due To Licorice Intoxication

HAROLD J. ROBINSON, M.D., F.A.C.P.

FRANK S. HARRISON, M.D.

and

JOSEPH T. L. NICHOLSON, M.D.

Bryn Mawr

'Within the infant rind of this weak flower
poison hath residence, and medicine power.'

Romeo and Juliet, Act II, Sc. iii

POTASSIUM was recognized by Ringer in 1883 as essential for normal myocardial function.[1] Structural as well as functional abnormalities of the cardiovascular system resulting from potassium ion depletion have been well documented.[2] Hypokalemia has been associated with multiple etiologies including prolonged diarrhea or vomiting, familial periodic paralysis, primary aldosteronism, a variety of renal abnormalities, diabetic acidosis, severe alkalosis, versene poisoning, and corticosteroid or diuretic therapy.[3] The kaluretic effect of licorice ingestion is a less frequently considered etiology for potassium ion depletion.[4]

The case reports of licorice induced hypokalemia reviewed by other authors emphasized the disturbances of neuromuscular function, renal function, acid base equilibrium and hypertension. The case reported below, however, describes significant cardiac dys-

function associated with licorice ingestion.

Case Report

A 73 year old retired man experienced the sudden onset of palpitations and dyspnea during moderate exertion. This was associated with pallor, diaphoresis, and fecal incontinence. There was no cyanosis, cough or chest discomfort. He had never previously had a serious illness or signs or symptoms of myocardial decompensation, coronary artery insufficiency or thrombophlebitis. He had been bothered by a morning cough until he stopped smoking three months earlier. For the previous three weeks he had been aware of polydipsia and a dry throat. He was first examined by his physician two hours after the episode of palpitation and dyspnea and found to have a blood pressure of 150/85 and no evidence of myocardial decompensation. However, the heart was rapid and irregular.

Several hours later an EKG was found to be abnormal and the patient was brought to the emergency ward of the Bryn Mawr Hospital for admission. At that time he was slightly cyanotic and dyspneic but had warm, dry skin. His blood pressure was 200/110 but soon thereafter fell to 150/90. His pulse was 120 beats per minute and irregular. The neck veins were slightly distended and a prominent and occasionally irregular A wave (not "cannon") was followed by a small V wave. Diminished breath sounds and hyperresonance were associated with occasional wheezes. The heart was not enlarged. The first heart sound was constant in intensity and an occasional brief, faint, apical, systolic murmur was heard. There were no gallop sounds. His abdomen was normal. There was no calf tenderness or pedal edema.

An EKG showed a supraventricular tachycardia of 140 beats per minute with frequent premature atrial contractions, the latter occasionally blocked. An intraventricular conduction defect was present (Figure 1). Oxygen and heparin were started and during the next twelve hours he was digitalized intravenously and showed improvement. However, the EKG then showed a supraventricular tachycardia at 190 beats per minute with two to one AV block. Quinidine, 80 mgs. IM was administered followed by 200 mgs. orally every six hours. The supraventricular rate then increased to 210 per minute with a two to one block and shifting supraventricular focus (Figure 1). Digitalis® (Lilly) was withheld and quinidine stopped. Serum electrolytes showed a marked hypokalemic alkalosis with a potassium of 2.5 milliequivalents per liter and a bicarbonate of 74 volumes percent with a capillary pH of 7.525. Intravenous potassium chloride was initiated.

The patient denied consuming antacids, unusual foods, or any of his wife's thiazide tablets. He had had no vomiting or diarrhea. There was no history of hypertension or kidney disease. In fact, there was no explanation for his marked hypokalemia until that night, twenty four hours after admission, when he jokingly suggested that the licorice he ate might be the culprit! He had consumed approximately 124 gms. daily for the past three months as a substitute for the cigarettes he had discontinued. The diagnosis of licorice intoxication was then suspected. The urine specific gravity was 1.010 and a pH 6.75. Intravenous potassium chloride was increased and two twenty four hour urine collections were sent for aldosterone determinations (Figure 2).

Within twenty-four hours of initiating intravenous potassium chloride, regular sinus rhythm appeared. The serum potassium was then 3.4 milliequivalents per liter. However there followed two episodes of acute dyspnea and diaphoresis associated with a rise in blood pressure to 210/130 and a tachycardia of 180 beats per minute with the appearance of moderate rales and wheezes. Both of these episodes had been precipitated by straining at stool and both responded to emergency treatment with oxygen, Aminophyllin® (Searle), and resumption of digoxin. Soon after the second episode his blood pressure fell to 80/50 and a serum potassium was found to be 2.9 milliequivalents per liter. SGOT's had been normal and an LDH was slightly elevated at 610 units. The blood sugar, BUN, and T3 in-vitro-uptake were normal.

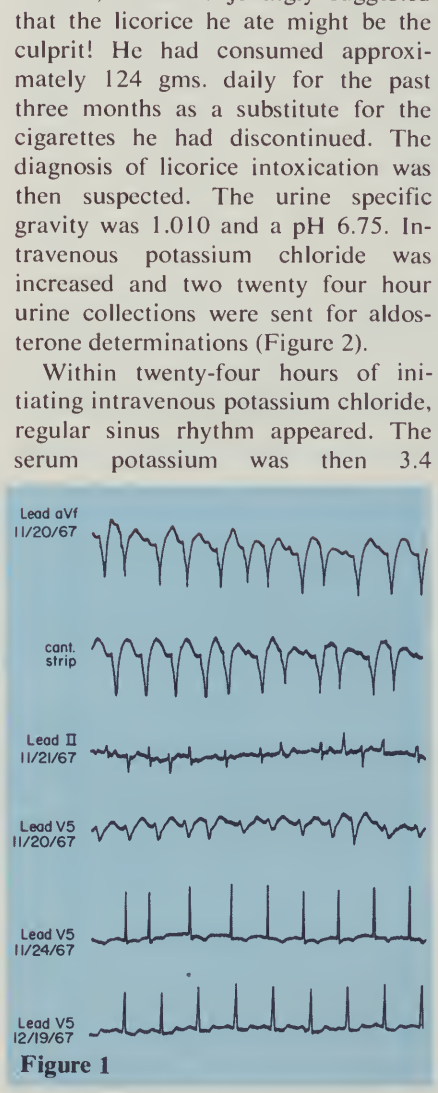

Figure 1

On the third day Aldactone® (Searle) 25 mgs. q.i.d. was initiated. The pulse rate ranged between 80 to 110 beats per minute and there were some dependent wheezes and rales. On the fourth day there was another dyspneic crisis similar to those described above but now associated with a temperature of 104 degrees rectally. Penicillin was initiated but was replaced 48 hours later by Ampicillin in a dose of 9 gms. daily intravenously. Rust-streaked thick sputum was cultured and pneumococci were grown. There was a leukocytosis of 13,350 with a slight shift to the left. The blood cultures were negative. A similar episode of marked dyspnea again occurred on the sixth hospital day and was associated with atrial fibrillation. The patient had become incontinent and had a poor oral intake. However, by the eighth hospital day he had improved.

The urine potassium excretion rose to 119 milliequivalents in twenty-four hours and the serum potassium was 4.4 milliequivalents. Intravenous potassium chloride was discontinued. By the tenth day the patient had become afebrile and his appetite improved. A sinus tachycardia with occasional PAC's persisted. The serum potassium was again normal and remained so throughout the rest of his hospitalization without benefit of potassium supplement.

Subsequently the patient's pulse slowed, although occasional premature contractions persisted. Antibiotics were stopped. The urine aldosterone levels collected on the second and

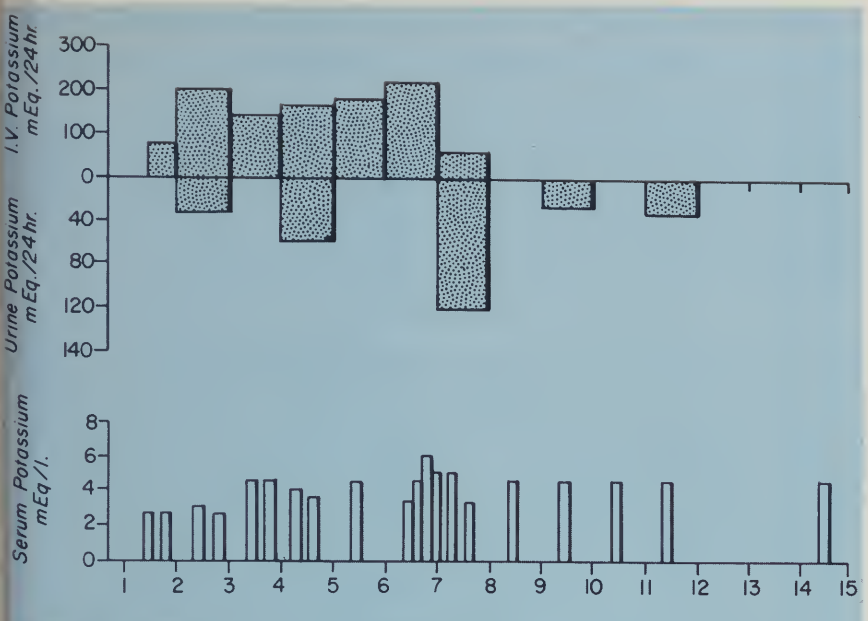

Figure 2 — Part 1

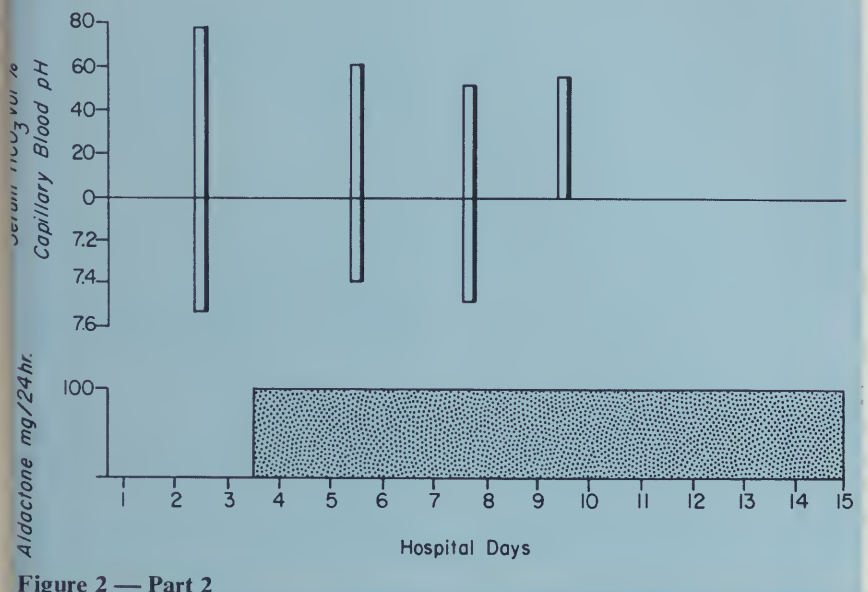

Figure 2 — Part 2

ird day were reported as being 3 id 4 micrograms respectively (normal o to twenty-six micrograms per 24 ours). Aldactone was stopped but igitalis continued.

Throughout the early part of the pa-ent's illness the EKG had shown left is deviation and symmetrical T-wave version in leads 2,3,AVF, and V-4,5, id 6. The influence of hypokalemia, e arrhythmia, and Digitalis was ap-eciated but the possibility of yocardia injury secondary to the pokalemia was also considered. By e time of discharge the T-waves had iproved to normal and the residual ST segment change could be attributed to Digitalis effect (Figure 1).

Prior to discharge a repeat urine aldosterone was obtained and again found to be normal. However, the urine specific gravity remained low and rose to only 1.013 following twelve hours of abstinence from fluid. The probability of tubular changes secondary to hypokalemia were considered.

A subsequent urine analysis after discharge showed a normal specific gravity of 1.026 and pH of 6.

The patient was discharged after thirty-three days in good condition on Digitalis maintenance. He was requested to abstain from ingestion of licorice!

Dr. Robinson is presently assistant attending cardiologist at Bryn Mawr Hospital and an instructor in cardiology at the University of Pennsylvania School of Medicine's Graduate Division. Dr. Harrison is the acting chief resident at Bryn Mawr Hospital, and Dr. Nicholson, attending physician for the service of internal medicine at Bryn Mawr Hospital.

Discussion

In 1946, Rivers observed that 20 per cent of his patients treated for gastric ulcer with a crude extract of licorice developed weight gain and edema.[5] Groen et al. recorded the beneficial effects of administering licorice to Addison disease patients.[6] Licorice was then shown to cause sodium and chloride retention with increased potassium excretion in normal man.[7] The active compound was found to be glycyrrhizic acid.[8] This acid had initially been investigated by Bergman in 1933 and was determined to be a combination of glucuronic acid and glycyrrhetinic acid. The latter, being the significant compound resembles a cyclopentanophenanthrene steroid.[9] In 1956 Lewis and Conn outlined a method of preparing a pure glycyrrhizinic acid and reported the metabolic and physiologic effects exhibited by normal subjects.[10] The patients received 4 to 6 gms. of ammonium glycyrrhezinate per day. The authors confirmed that this active principal of licorice induced retention of sodium chloride and water and produced an increase in urinary potassium excretion. They also found an inhibition of endogenous production of ACTH.[10] To further qualify the substance as an active mineral corticoid, a patient taking large quantities of licorice (55 gms./day) was given spironolactone by Salassa. Spironolactone successfully reversed the change in the potassium and sodium excretion abnormalities correcting the hypokalemic alkalosis. No aldosterone was detectable in the patient's urine.[11]

In Welt's review of the consequences of potassium depletion the cardiovascular effects are placed into

structural and functional categories.[1] The common feature of structural change is muscle necrosis. The subendocardial and papillary muscle areas are the most extensively involved. The earliest changes observed are swelling and loss of muscle striation. Fibers then become necrotic and disappear and the nuclei shrink. The appearance of leukocytes is followed by the presence of tissue macrophages and fibroblastic proliferation.[2,12,13] The two clinical cases reported by McAllan revealed widespread myocardial fibrosis with normal coronary arteries. He concluded that a long severe potassium depletion may result in significant myocardial damage.[2] Congestive heart failure may result.[14] Changes in virtually every part of the electrocardiogram have been also reported. Most commonly observed have been an ST segment depression and depressed or inverted T-waves along with exaggeration of the U-wave. Investigators agree that the electrocardiogram pattern is not consistently related to the serum potassium level or total potassium deficit.[1,15] The increased myocardial excitability associated with hypokalemia sometimes results in an arrhythmia. The most common are ventricular and atrial premature contractions but bigeminal rhythm, atrial flutter, and tachycardia have also been observed.[1,16]

In 1956 Relman and Schwartz reported five cases of nephropathy secondary to potassium depletion. These changes are characterized primarily by impaired tubular function resulting in a concentration defect which is resistent to vasopressin administration.[17] Alterations of acidification, depression of glomerular filtration rate, and an increased susceptibility to pyelonephritis have also been reported. The most common pathologic changes in human subjects is vacuolization of the tubular epithelium primarily of the proximal convoluted tubules. No significant glomerular or vascular changes have been observed.[17] The renal abnormalities were reversible in most of the reported cases. Polydipsia has been noted and may be related to the impaired concentration process.[1]

In addition to sodium and water retention and potassium depletion, hypertension, occasionally severe, has been reported as a consequence of licorice ingestion.[18] Thus, all the effects of hyperaldosteronism have been demonstrated and indeed these effects have been blocked by the use of Spironolactone.[11] Unlike hyperaldosteronism, however, licorice induced pseudoaldosteronism is not associated with a rise in aldosterone secretion nor a supression of plasma renin activity.[19]

Conclusion

Until our patient volunteered the history of habitual licorice ingestion no etiology for his severe hypokalemic alkalosis was apparent. Never known to be hypertensive, he consistently denied a history of gastrointestinal or renal disease and, despite our suspicion, denied ever using his wife's diuretics. We believe that both the arrhythmia and the EKG abnormalities, suggesting myocardial injury, were the result of his hypokalemia. His renal tubular insufficiency was likewise attributable to this defect. After his discharge, subsequent tests of urinary pH and specific gravity showed a return to normal. Most recently, six months after he was discharged, his urine pH was 6 and specific gravity 1.026. It was difficult for us to determine the sequence of events during his recurrent crises. Whether acute myocardial decompensation, a recurrent tachyarrhythmia, or acute hypertension precipitated these crises is uncertain. The latter seems unlikely since he responded to therapy for congestive failure and to intravenous potassium chloride rather than any specific antihypertensive measure.

Although the motivation for our patient's licorice ingestion was more justified than that of the alcoholics who imbibed the crude extract when enjoying their "un boisson de Coco,"[20] the effect was nonetheless equally severe. □

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Clinical Applications Of The Australia Antigen Test

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THE DIAGNOSIS of viral hepatitis has depended upon three basic clinical methods: evaluation of the patient's history and physical findings, laboratory evidence of liver dysfunction (especially elevation of SGPT), and needle biopsy of the liver. It has been established that the true incidence of hepatitis is from five to one hundred times that which is diagnosed because most cases have a mild illness without jaundice that escapes the attention of the physician.[1] Studies on post-transfusion hepatitis indicate that the majority of cases, as determined by rise in SGPT, do not develop jaundice and many have no symptoms.[1,2] Thus, there must exist a vast reservoir of hepatitis 'carriers' capable of spreading the disease by blood transfusion or other means. The lack of specific serologic methods for detecting hepatitis and the failure to isolate a causative agent have been the major obstacles in solving this problem.

In 1963 Blumberg made an observation which later proved to be a crucial step in the development of a specific serologic test for viral hepatitis.[3] While studying the development of precipitating antibodies to serum lipoproteins in patients who had received many blood transfusions, Blumberg found an antibody in the serum of a hemophilia patient which reacted with the serum of an Australian aborigine. The antigen appeared to be a unique substance and not a normal blood component. It was given the name Australia antigen, abbreviated Au (1).[4] When populations were studied for the presence of the antigen several interesting facts emerged. First, the antigen was very rare in the general United States population, but rather common in some tropical areas.[4] It was found to be present in high frequency in patients with the following diseases: viral hepatitis, both 'infectious' and post-transfusion, Down's syndrome, lepromatous leprosy, and leukemia.[4,5] Studies in our laboratory, later confirmed by many laboratories throughout the world, soon made it evident that the presence of Au (1) in the blood was clearly associated with viral hepatitis.[6,7,8,9,10,11,12] Other names such as hepatitis antigen, SH antigen, and hepatitis associated antigen were used by some investigators to emphasize this association.

The patients with Down's syndrome who had Au (1) were found to have evidence of chronic, anicteric hepatitis, and among the patients with leukemia the presence of Au (1) was associated with a history of blood transfusion.[13] Moreover, the transfusion of blood containing Au (1) results in a high incidence of hepatitis and Au (1) among the recipients.[14,15,16]

Australia antigen has been isolated from the blood and appears as virus-like particles under the electron microscope.[17] It is still uncertain whether Au (1) actually is a virus, some component of a virus, or a cell product formed as a result of viral infection. In any event, the finding of Au (1) in a high percentage of patients with viral hepatitis and its absence in other liver diseases renders the Au (1) test a useful diagnostic tool.

Laboratory Methods for Detecting Au (1)

Au (1) can be detected by a variety of immunologic techniques. The antibody used in these tests can be produced in rabbits, mice, guinea pigs and other animals. The antibody can also be found in the blood of some multiply-transfused patients. The standard method for detecting Au (1) has been the Micro-Ouchterlony technique which involves double diffusion in agar gel.[18] Wells are punched on a plate of agar gel. The center well is filled with antibody and the peripheral wells filled with the serum or other fluid to be tested. A clear precipitin line will occur where antigen and antibody meet in appropriate concentrations. This method requires twenty-four hours before an initial result is available. However, it is relatively easy to perform and is useful in screening a large number of samples.

A modification of the double diffusion technique has now been developed and applied to Au (1). This is called crossover or 'reaction' electrophoresis[19,20] and takes advantage of the fact that Au (1) and the antibody to it migrate in opposite directions when placed in an electrical field. Antibody is placed in a well near the anode and the serum containing the antigen near the cathode. When current is applied the antigen and antibody move toward each other and a precipitin band will form where they meet. This speeds the reaction so that a result is usually seen in one to one and a half hours. The sensitivity is also increased because the antigen and antibody are being concentrated in one direction. This method may prove to be the ideal way of rapid testing for Au (1) such as would be required in blood banks.

Au (1) can also be detected by a complement-fixation test.[21,22] This test is more sensitive than immunodiffusion but less specific and somewhat more difficult to perform. Other more sensitive methods such as radio-immunoprecipitation assay, have been developed and will be available in the future.

Significance of a Positive Au (1) Test

The finding of Au (1) in the blood of a patient suspected of hepatitis gives strong evidence that the patient has viral hepatitis;a negative result however does not rule out this diagnosis. The incidence of Au (1) in hepatitis varies in different series. In most reports it has been found in about 60 to 80 per cent of cases of post-transfusion hepatitis and anywhere from 0 per cent to

as high as 80 per cent in cases diagnosed as infectious hepatitis.[5,6,10] It has been shown that Au (1) appears in the blood very early in the course of the disease and usually before any signs or symptoms of illness appear. The usual course in acute hepatitis is that Au (1) is present very early, and disappears by the time of peak rise in SGPT. In some cases Au (1) has been detected for only one or two days. Therefore it is important to test the blood of suspected hepatitis patients early in the illness and to do repeated testing on several days. In some patients who have a prolonged illness Au (1) may persist in the blood for several weeks or months. In these patients the persistence of Au (1) for more than four weeks may herald a course of chronic hepatitis.[23] Some people with persistent Au (1) have no evidence of liver disease by clinical laboratory studies or liver biopsy. Although not sick, they potentially may transmit hepatitis to others.

There are several chronic disorders which are associated with persistent Au (1) without manifestations of acute liver disease. These include Down's syndrome, chronic renal disease, lepromatous leprosy and leukemia. All of these diseases are known to have some degree of impairment of immune response. These patients have a low grade form of hepatitis which may not be clinically evident, but may persist for months or years. Some have no evidence of hepatitis at all.

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Clinical Applications

In addition to its usefulness in diagnosing hepatitis at a very early stage, the Au (1) test has other important applications. By screening all blood donors and eliminating all Au (1) positive blood, it is estimated that the incidence of post-transfusion hepatitis could be decreased by about 25 per cent.[17] With more sensitive methods of detecting Au (1) that percentage could be increased. The Au (1) test has already proven its usefulness as a means of surveillance of groups that have a high risk of contracting hepatitis. These include laboratory workers involved with blood or blood products whether this be in a clinical laboratory, industry or research; animal handlers working with non-human primates who have been shown to carry Au (1);[24] and patients and personnel of renal dialysis units where 'epidemics' of hepatitis have been reported.[25,26] It would also be of value in surveillance and control of hepatitis in institutions for the mentally retarded, and perhaps other closed institutions.

The application of the Au (1) test as a research tool are far-reaching. Hopefully it will lead to further understanding of the pathogenesis of viral hepatitis and provide some insight into the variation of individual response to this disease. The possibility that Australia antigen is a virus or a part of a virus also raises hope that it will be instrumental in bringing about the isolation of the causative agent of hepatitis. □

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Hemolytic Anemia Complicating Halothane Induced Hepatitis

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THE CLINICAL and pathological findings of Halothane induced epatitis have recently been reiewed.[1,2]

The case presented is that of a paent with halothane induced hepatitis, n whom hemolytic anemia was an acompanying complication.

Case Report

E. D., a 61 year old caucasian emale was hospitalized at the Harrisurg Polyclinic Hospital on November 2, 1969 for removal of an enlarging, ut otherwise asymptomatic mass, om her left cheek. The mass had een noted three years previously. Her ast medical history included a hyroidectomy approximately twenty-ve years ago and a hysterectomy in 964, both without complications. The type of anesthesia used at those times is undetermined. The patient denied known allergies and, other than the occasional use of aspirin for headache, denied use of medications.

Family history and review of systems were unremarkable. Physical examination revealed a thin Caucasian female who was in no distress and was afebrile. A firm 1 by 1½ centimeter immobile subcutaneous mass was noted in the left preauricular area. Vital signs were temperature — 98.6°, pulse — 76, and blood pressure — 100/60. The remainder of the physical examination was unremarkable. The liver and spleen were not palpable. A complete blood count revealed a hemoglobin of 10.3 grams per cent and hematocrit of 32 volumes per cent. The white blood count was 5,700 per cubic milimeter. The peripheral blood smear revealed hypochromic red cells. The platelet count was normal. Urinalysis was normal. Serum glutamic oxaloacetic transaminase was 10 units, alkaline phosphatase 11 units, and total bilirubin was 0.6 milligrams per cent. A chest x-ray was normal. The patient was taken to the operating room on the second hospital day and under halothane anesthesia, a left parotid tumor was excised. The pathologic specimen revealed a benign mixed tumor. The patient's operative and immediate post operative course was uneventful. There were no episodes of hypotension. No blood was transfused. The patient was discharged on the fifth post-operative day on multivitamins with iron. The patient remained well until four days after

TABLE I

	Serum glutamic oxaloacetic transaminase (normal 10-40)	Alkaline phosphatase (normal 4-17)	Bilirubin total (normal 1.0 mg. %)	Serum glutamic pyruvate transaminase (normal less than 50)
Admission 11/28/69	372	25	3.5	
Third hospital day	160	27	3.0	91
Eighth hospital day	37	19	1.6	
Tenth hospital day	35	12	1.2	58
Twelfth hospital day	27	12	0.9	

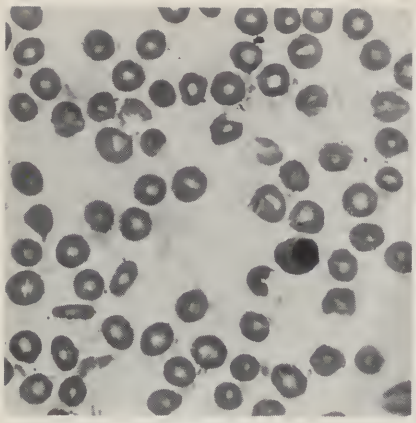

Figure 1

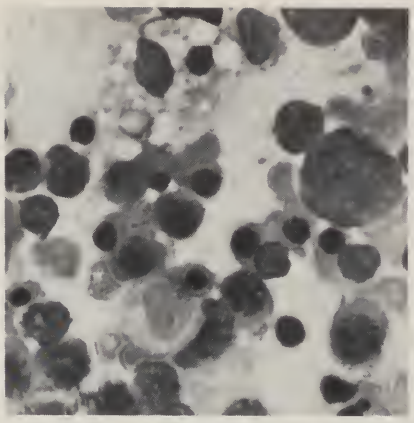

Figure 2

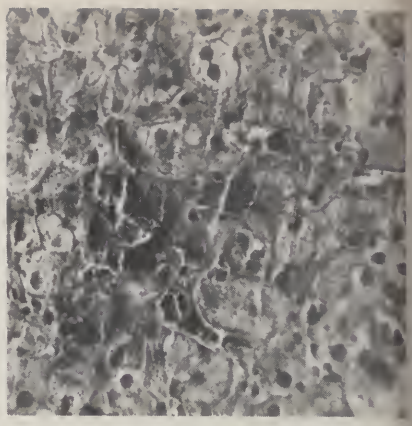

Figure 3

discharge. On the fifth day following discharge (ten days post-operatively), she noted the onset of lethargy and the loss of appetite. These symptoms subsequently became associated with jaundice, ankle edema, exertional dyspnea and dark urine. She had no apparent site of bleeding. The patient believed that she had had a mild fever throughout this period, but was unable to document this fact. The only medication she had been taking, other than her discharge medication, was aspirin for a persistent headache. On the tenth day following discharge, she was seen by her local physician who noted a low hemoglobin and advised rehospitalization.

Physical examination on admission revealed an acutely ill, pale, jaundiced female who was tachypneic. The blood pressure was 110/80, pulse 86 and regular. Fundoscopic examination revealed scattered hemorrhages on the left. The neck veins were flat and the lungs were clear. The heart was regular with a rate of 86. A grade 2 over 6 systolic ejection type murmur was noted along the left sternal border which radiated to the base. The liver was palpable five centimeters below the right costal margin and was tender. The spleen was not palpable. Bilateral pretibial edema was present. Neurologic examination was normal, with the exception of a post operative left facial nerve weakness. An admission complete blood count revealed a hemoglobin of 4.5 grams per cent, hematocrit of 14 volumes per cent and a white blood count of 7,020 per cubic millimeter, with a differential of 50 segmented neutrophils, 46 lymphocytes and 4 monocytes. The platelet count was normal. The peripheral smear (figure 1) revealed red cell anisocytosis and poikilocystosis with basophilic stippling, microspherocytosis, fragmented red cells and the presence of circulating normoblasts and plasma cells. Urinalysis and chest x-ray were normal. Serology was negative. Electrocardiogram was normal. A complete blood count on the morning

TABLE II

	Hemoglobin Gm. %	Hematocrit Vol. %	Reticulocytes %	Platelets per cubic millimeter	White blood count per cubic millimeter
Admission, 11/28/69	4.2	14			7020
First hospital day, 11/29/69 Prednisone was started, 2 units packed cells	3.7	13	38.7	280,000	5800
Second hospital day 2 units packed cells	7.5	25			8200
Fourth hospital day	10.7	35			8300
Fifth hospital day	12.7	40	12.4		7700
Sixth hospital day	13.4	41	12.8		6600
Eleventh hospital day	12.9	40	1.0	372,000	12000
Twelfth hospital day	13.1	41			11900

of the second hospital day revealed a hemoglobin of 3.7 grams per cent, hematocrit of 13 volumes per cent and white blood count of 5,800 per cubic millimeter. Platelet count was 280,000 per cubic millimeter. The sed rate was , which corrected to 0. Reticulocyte ount was 38.7 per cent. Serum glutamic oxaloacetic transaminase was 72 units, alkaline phosphatase was 25 nits, and total bilirubin was 3.5 milligrams per cent with 1.3 milligrams per cent direct reacting. Albumin was 3.5 grams per cent. Prothrombin time was 13.9 seconds with control of 12.9 seconds. Direct oombs test was negative. Bone narrow aspiration (figure 2) was performed on the second hospital day, prior to transfusion, and showed a hypercellular marrow with marked normoblastic erythroid hyperplasia and an increase in plasma cells. On the second hospital day the patient was given two units of packed red blood cells and started on prednisone 15 milligrams every six hours by mouth. On the third hospital day, the patient was given an additional two units of packed red blood cells. The hemoglobin following transfusions was 10.7 grams per cent and the hematocrit was 5 volumes per cent. Serum glutamic oxaloacetic transaminase on the third hospital day was 130 units. Total bilirubin was 3.0 milligrams per cent. Alkaline phosphatase was 28 units. By the eighth hospital day these values were serum glutamic oxaloacetic transaminase 35, bilirubin 1.6 milligrams per cent and alkaline phosphatase 19. (Table I)

Additional laboratory studies included negative LE preps, a serum iron of 175 micrograms per cent and a total iron binding capacity of 330 micrograms per cent. Serum protein electrophoresis was normal and serum protein immuno-diffusion revealed IgG of 1000 milligrams per cent (normal 600-1900 milligrams per cent), IgA 110 milligrams per cent (normal 50-400 milligrams per cent), and IgM 53 milligrams per cent (normal 40-250 milligrams per cent). Protein Bound Iodine (PBI) was 7.8 milligrams per cent. Cold agglutinins were negative. Erythrocyte osmotic fragilities were normal. Shilling test was 7 per cent without intrinsic factor. Gastric analysis demonstrated the presence of free acid. Serum amylase and lipase were normal. V.D.R.L. was non reactive. Urine urobilinogon was normal.

The patient continued to improve without further transfusions. On the sixth hospital day, the hemoglobin was 12 grams per cent and hematocrit was 37 volumes per cent. Prednisone was reduced to 10 milligrams four times per day. A percutaneous liver biopsy was performed without incident. The specimen obtained was consistent with early cholestatic hepatitis (figure 3). A complete blood count on the thirteenth hospital day showed a hemoglobin of 13.9 grams per cent and hematocrit of 40 volumes per cent. Reticulocytes were 1.0 per cent. (Table II)

A barium enema, sigmoidoscopy, and upper GI series were normal. Liver scan demonstrated hepatomegaly.

The patient was discharged on the sixteenth hospital day on a regime of prednisone 10 milligrams every six hours and iron. At the time of her discharge, her liver continued to be palpable and tender, and remained so for one month following discharge. At the present time, the patient is asymptomatic and all hematologic parameters are normal.

Discussion

Hepatitis is a rare, but well recognized complication of halothane anesthesia.[1] This patient presented a picture of acute hepatitis for which no apparent cause other than halothane anesthesia could be implicated. The patient received no blood transfusions and was taking no known hepatotoxins. She denied the use of alcoholic beverages. Insofar as is known, she had not been exposed to active hepatitis. She had no episodes of hypotension. In light of her clinical course and previous observations[2,3] we have concluded that the hepatitis seen in this patient was halothane induced.

Drs. Ricci, Gross and Shields are presently working in the Harrisburg Polyclinic Hospital's division of medicine. Dr. Ricci is also clinical instructor in the department of medicine at Hahnemann Medical College and Hospital in Philadelphia.

An unusual feature in this patient is the associated severe hemolytic anemia with which she presented.

At the time of her surgery, she was noted to be mildly anemic and because of hypochromic red cells, placed on iron. In light of the fact that her hemoglobin has remained normal following the discontinuing of prednisone, but while continuing iron, we have concluded that her mild anemia preoperatively was truly iron deficiency, despite no obvious cause being found.

The transient nature of the hemolytic anemia, which improved as her liver function improved, would indicate that the hepatitis was involved as mechanism for her anemia.

In so far as could be determined, there existed no other cause for her hemolytic state. As in most cases of hepatitis, the Coombs test was negative.[4,5] Numerous other studies as to etiology of the patient's anemia all were within normal limits. Therefore, the severe anemia with which she presented at the time of the hepatitis was, as proven by the studies obtained, hemolytic in nature.

Of importance, is the observation of fragmented red cells noted in the peripheral smear. This, we believe, was an indication of red cell entrapment within the liver parenchyma, resulting in deformed cells and consequent destruction. This has been suggested as a mechanism of hemolysis in hepatitis.[5,6] □

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The Physician, His Assistants, And Pennsylvania Law

ADVISORY COMMITTEE ON MANPOWER AND ALLIED PROFESSIONS
Council on Education and Science

What is the responsibility of a physician for the actions of allied medical employees utilized by such physician?

Pennsylvania Law

Pennsylvania law is clear. Whether the allied person works directly for the physician in his office or in the hospital, or whether such allied medical personnel works in his own office under the direction of a physician, (such as a dispensing optician and contact lens fitter or a MEDEX person in the field on his own) the legal responsibility of such allied medical personnel rests with the physician. If the allied medical person is guilty of negligence in the care of the patient, the physician is normally liable for the consequences flowing from such negligence, including damages flowing from a malpractice suit.

Safeguards Against Liability

The best safeguard against physician liability for the acts of his allied medical personnel is to employ only persons qualified for the procedures they are performing, to constantly supervise them, and to make certain that they do not perform procedures which they are not qualified to do.

The matter of licensure or certification of allied medical persons does not change the fact that the physician is responsible for the act of his assistant. Its real value is that it allows the physician employer to presume that the licensed or certified allied medical employee is competent in his or her field, at least until he or she is found to be actually incompetent.

Physician Normally Responsible

If something goes wrong and negligence of the allied medical assistant causes injury to a patient, the physician-employer will normally be held responsible. The fact of a license or certification does not change this. In summary, *the physician is normally responsible for the acts of his allied medical assistants.*

Malpractice Insurance

Malpractice insurance carriers show great concern regarding the trend toward the use of more and more allied medical personnel by the physicians they insure since the risk is heavily enhanced inasmuch as the physician is normally responsible for negligent acts of his allied medical assistants. The physician should counsel with his insurance carrier to be sure that his malpractice policy covers the acts of the nonphysician medical assistant.

It appears at this writing, from a practical point of view, that the physician's allied medical employees, who are not hospital based, will have to rely upon the broadened coverage of their physician-employer to cover them for their negligent acts.

Change May Come

Just filed in February, 1971, by the Insurance Rating Bureau with the Pennsylvania Insurance Department is a request for a new classification for 50 per cent of the charge of Risk Class I to cover the physician or surgical assistant. The filing recommends that the physician or surgical assistant who has completed an approved course of study leading to university certification and who performs his duties under the direct supervision of a physician be provided with malpractice insurance. If the Pennsylvania Insurance Department approves this classification of physician's assistant, the insurance companies will have a rule to follow in determining rates and coverage.

KNOWLEDGE of the law lowers risk of a suit.

PENNSYLVANIA MEDICINE cardiovascular brief

Aneurysms

David Naide, M.D. and Meyer Naide, M.D., Division of Vascular Diseases, Graduate Hospital of the University of Pennsylvania, are questioned by William G. Leaman, Jr., M.D.

How are abdominal aneurysms usually discovered?

They are usually found either on routine abdominal examination by the presence of a mass or bruit or on abdominal or spine x-rays taken for other purposes. They will show up on a plain x-ray only if there is calcification in the wall of the aneurysm. If all patients over fifty years of age were to have a PA and lateral x-ray of the abdomen as part of their routine examination, early diagnosis of aneurysms could be made much more frequently.

What symptoms may result from an abdominal aortic aneurysm?

Aneurysms are often asymptomatic. Pain in the back or abdomen may be a presenting symptom. With leaking or rupture the patient presents as an abdominal emergency, often in a state of collapse.

What other studies may help, particularly where there may be a question as to the diagnosis, such as differentiation of abdominal aortic aneurysm from an abdominal mass (tumor)?

Aortography will usually give the answer, though occasionally one can be fooled into thinking an aneurysm is not present if one sees a normal channel in the aorta because the rest of the aneurysm is filled with laminated thrombus. There are newer, relatively innocuous, research technics using ultrasound which may also be helpful.

What are the dangers of an abdominal aortic aneurysm if left alone?

There may be progressive dilatation and eventual rupture; but, unfortunately, they are not predictable. The incidence of rupture rises steeply with aneurysms 6-7 cm. or greater in diameter. Occasionally, there may be thrombosis of the aneurysm leading to complete occlusion of the aorta and peripheral ischemia. Frequently, a laminated thrombus may form in the wall of the aneurysm, and this can embolize distally.

When do you decide whether surgery should be performed for an abdominal aneurysm?

If the aneurysm is over 4.5 cm. in diameter, even if asymptomatic, or if it is producing symptoms (which might indicate weakening of the aortic wall), even if it is smaller than 4.5 cm., the patient should be operated on, if his general condition will permit this major procedure. The procedure performed is excision of the aneurysm and by-pass of the diseased area. If the patient is not operated upon, serial plain x-rays should be taken every three to six months, to see if the aneurysm shows progressive enlargement which might prompt surgical intervention.

What are the contraindications to resection of an aneurysm?

In patients with short life expectancy, such as in the presence of carcinoma or severe cardiovascular or renal disease with great risk from major surgery, resection of the aneurysm is usually not recommended. However, leading or rupture of the aneurysm is an absolute indication for resection of the aneurysm.

What about popliteal aneurysms?

These are frequently bilateral and usually found on routine examination of the popliteal pulse. When found, they should be surgically resected and a vein by-pass inserted because they have a high incidence of causing distal embolization from a laminated thrombus in the aneurysm. They may also thrombose. When popliteal aneurysms occlude, the incidence of loss of limb is high. The same statements apply to femoral artery aneurysms.

What does one do with multiple aneurysms?

Occasionally a patient is seen with a generalized dilatation of the iliac, femoral and popliteal vessels (ectasia) or multiple aneurysms along these vessels. These are often very difficult to resect because the vessels are so diseased and, therefore, are usually best left alone.

How often are visceral aneurysms found and how are they managed?

Splenic, renal, celiac and hepatic aneurysms are uncommon but may be discovered as incidental findings in x-rays taken for other causes, if the aneurysms are calcified. They may also be found incidentally on arteriography. The decision as to whether to operate depends on the age of the patient, whether or not it is calcified and whether symptoms are present. There is greater incidence of rupture during pregnancy. Also, the vessel involved may be the determining factor, since the incidence of rupture is least with renal and greatest with hepatic, with splenic aneurysms being in the middle.

William G. Leaman, Jr., M.D., edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.

PENNSYLVANIA MEDICINE cancer forum

Who Should Treat Leukemia?

JOHN L. GROSH, M.D., GUEST EDITOR

Chief of Medicine
Lancaster General Hospital
Lancaster

The subject of who should treat leukemia has been somewhat controversial in recent years, although to properly discuss the subject, the question must be divided into the treatment of Acute Leukemia, Chronic Leukemia, and Multiple Myeloma. In my opinion, the treatment of the Chronic Leukemias and Multiple Myeloma and their complications can very well be handled by an experienced hematologist in a community hospital.

Chronic Lymphatic Leukemia was originally treated with Fowler's Solution, and/or, some form of total body irradiation in low dosage. Since 1943, other drugs, P_{32} Chlorambucil, Phenylalanine Mustard, Cyclophosphamide, etc. have come into common use. Chlorambucil (Leukeran) is probably the drug of choice. Associated anemia may occur as a hemolytic process and is treatable with corticosteroids, or splenectomy. For the anemia secondary to drug therapy, testosterone may stimulate erythropoesis. There are those who feel that chronic lymphatic leukemia should not be treated at all, unless it is symptomatic or unless there are existing complications.

Chronic Myelogenous Leukemia should be treated as soon as the diagnosis is made. The previous standard form of therapy with splenic irradiation has been fairly well supplanted by the use of Busulfan (Myleran). It is inevitable that resistance to therapy will eventually develop, and a terminal blastic crisis will ensue. Then, therapy is somewhat fruitless, although 6MP, Hydroxyurea, Vincristine, and Alkeran may be temporarily helpful.

Multiple Myeloma is not commonly a disease of the peripheral blood. However, a plasma cell leukemia does occur in a small number of cases. Therapy is best carried out with Melphalen (Alkeran) plus Prednisone. This combination of drugs can result in a sixty five percent remission rate. Local x-ray plus fluoride and testosterone can be adjunctive therapeutic measures.

According to Burchenal, Frei, Holland, and others, the treatment of Acute Leukemia should be aggressive and optimum. This type of treatment requires great experience, tremendous facilities and the thesis that a cure, not palliation, is the major objective. Aggressive treatment of Acute Lymphatic Leukemia in children has afforded the most encouraging results, and probably should always be carried out in a chemotherapy center. The treatment is with various multiple drug therapies such as VAMP, BIKE, POMP, and COAP. The treatment is toxic and almost sub-lethal, and results in many serious complications which are best handled in a major leukemia center. In adults, Lymphatic Leukemia is also treated with encouraging results if an aggressive program is followed.

The treatment of Acute Myelocytic, Monocytic, Promyelocytic, and Monomyelocytic Leukemias is a most discouraging problem. Crosby and others question the advisability of any therapy at all, except perhaps steroids and transfusions. These are diseases of the adult and the patient probably should be allowed to decide about therapy in the community hospital or treatment in major center. At best, therapy is questionable and remissions are short-lived. Induction with Vincristine and Prednisone and alterating 6 MP and Methotrexate can be beneficial, but not curative. The hematologist in the community hospital can usually manage such therapy.

Supportive measures to control hemorrhage and infection are, of course, also necessary. The aggressive use of the newer drugs, ARA-C, BCNU, L. Asparaginase, etc. is best left to major centers. At present the aggressive therapy should probably be reserved for Acute Lymphatic Leukemia, and primarily those cases in young individuals.

In the future, the use of immunotherapy and newer, as yet unproven, drugs hold some promise in this aspect of cancer chemotherapy.

CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.

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Actions—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FHS) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain [1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted; anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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INTERMITTENT COURSES

Listed below are courses of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, contact the director at the address given in the course listing.

GASTROENTEROLOGY

Philadelphia; January 14—April 18, 1971
I/AMA—SYSTEMATIC REVIEW OF GASTROENTEROLOGY; by U. of Pa.; at Lecture Room A; 4 hrs. ea. day; 1 day ea. week; 8 weeks; 32 hrs. AAGP credit requested; $150 fee. Contact Aaron D. Freedman, M.D., Assoc. Dean, U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

GENERAL MEDICINE

Aliquippa-Rochester Hosps. (rotation); third Wed., ea. mo.
Altoona Hospital; fourth Thurs. ea. mo.
Greensburg (Westmoreland Hosp.); first Tues. ea. mo.
Johnstown (Conemaugh Valley Mem. Hosp.); first Thurs., ea. mo.
Natrona Heights (Allegheny Valley Hosp.); second Tues. ea. mo.
Uniontown Hospital; last Mon. ea. mo.
Washington Hospital; first Wed. ea. mo.

O/I—DIAGNOSIS AND MANAGEMENT OF HYPERTENSION; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin P. Shapiro, M.D., Project Dir., 501 Flannery Bldg., 3530 Forbes Ave., Pittsburgh 15213.

Allentown; September 2, 1970—May 5, 1971
I—TEAM APPROACH TO PATIENT CARE (Fall-Winter Education Program); at Sacred Heart Hosp.; first Wed. ea. mo.; 3 hrs. each day; AAGP credit applied for. Contact Vincent J. Jerant, M.D., Chm. House Staff & Educ., Sacred Heart Hosp., 4th & Chew Sts., Allentown 18103.

Altoona Hospital; October 15, 1970—May 20, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every other Thurs.; 7 months; 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 17, 1970—May 20, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Luke's Hosp.; third Thurs. ea. mo. (except December); 8 mos.; AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford/Kane; October 20, 1970—May 18, 1971

CODE KEY

C—Consecutive days
I—Intermittent
O—Circuit
PG—Postgraduate Traineeship
S—Designed for full-time specialists
AMA—AMA Accredited Institution
CES—Council on Education and Science, Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
Hershey—Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Pitt—University of Pittsburgh, School of Medicine
Pitt P.H.—University of Pittsburgh, Graduate School of Public Health
Penn State—Pennsylvania State University
Temple—Temple University Health Sciences Center
U. of Pa.—University of Pennsylvania, School of Medicine
Woman's—The Medical College of Philadelphia

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; alternately at Bradford's Penn Hills Club and Kane Manor; third Tues. ea. mo.; 18 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Chester; September 8, 1970—May 25, 1971
I/AMA—POSTGRADUATE SEMINARS FOR PHYSICIANS; by Hahnemann; at Crozer-Chester Med. Center; 2 hrs. AAGP credit approved ea. day; 38 days; a day ea. week. Contact James E. Clark, M.D., Chief of Med., Crozer-Chester Med. Center, 15th & Upland Sts., Upland, Chester 19013.

DuBois Hospital; February 4—April 8, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Thurs.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

East Stroudsburg; October 17, 1970—April 17, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at General Hosp. of Monroe Co., third Sat. ea. mo., (except December); 18 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Erie; September 17-18, 1970—May 13-14, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Vincent's Hosp.; Thurs. eve. and Fri. morn.; approx. once every three weeks; 39 hrs. AAGP credit applied for. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Gettysburg; January 12—April 21, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at Annie Warner Hosp.; alternating Tues. and Wed. every other week; 24 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Harrisburg; November 10, 1970—May 11, 1971
I/AMA—CONTINUING EDUCATION COURSE; by Hahnemann; at Harrisburg Polyclinic Hospital; once ea. month. Contact David A. Smith, M.D., D.M.E., Harrisburg Polyclinic Hosp., Harrisburg 17105.

Hazelton State Gen. Hosp.; September 2, 1970—May 26, 1971
I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hazelton Branch of Luzerne Co. Med. Soc., and Hosp.; 1½ hrs. per day; 1 day per week; 36 weeks; 30 hrs. AAGP credit. Contact Robert L. Gunderson, M.D., Dir. of Med. Educ., Hazelton State Gen. Hosp., Hazleton, Pa. 18201.

Johnstown; November 24, 1970—May 25, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Conemaugh Valley Memorial Hosp., fourth Tues. ea. mo. (except Jan.); 6 sessions, 2 hrs. ea.; 12 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lancaster General Hosp.; September 22, 1970—May 18, 1971
I—CONTINUING MEDICAL EDUCATION PROGRAM; 1 day ea. week; 18 weeks; 3 hrs. AAGP credit applied for ea. session. Contact John H. Esbenshade, Jr., M.D., Dir. of Medical Educ., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17601.

Lancaster Osteopathic Hosp.; October 8, 1970—March 11, 1971
I/AMA—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; 16 Thursdays; 2 hrs. ea. day; Contact Harold F. White, D.O., Chmn., Prg. Comm., Lancaster Hosp., 1100 E. Orange St., Lancaster 17602

Lebanon; November 3, 1970—May 4, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Quentin Riding Academy; first Tues. every other month; AAGP credit requested. Contact John Killough, Ph.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lewistown Hospital; February 10—April 14, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Wed., ea. mo.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Lock Haven Hospital; October 21, 1970—May 5, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society 20 Erford Road, Lemoyne 17043.

Meadville; September 2, 1970—May 5, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first Wed. ea. mo. at Spencer Hospital; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Philadelphia; September 14, 1970—May 17, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Methodist Hosp.; first and third Mon. ea. mo. (except holidays); AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Pottsville; September 24, 1970—May 27, 1971
I/AMA—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; at Good Samaritan Hosp.; fourth Thurs. ea. mo. (except Nov., Dec. and Apr.); 2 hrs. ea. day. Contact Norman M. Wall, M.D., Dir. of Med. Educ., Good Samaritan Hosp., E. Norwegian and Tremont Sts., Pottsville, 17901.

Pottsville Hospital; September 3, 1970—June 3, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; first Thurs. ea. mo.; 10 mos.; 2 hrs. AAGP credit approved per session. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

Reading; September 22, 1970—May 25, 1971
I—1970-71 CONTINUING EDUCATION PROGRAM; at St. Joseph's Hosp.; fourth Tues. ea. mo. (except December); 8 hrs. AAGP credit requested. Contact Kenneth M. Schreck, M.D., Med. Dir., St. Joseph's Hosp., 215 Walnut St., Reading 19603.

Reading; October 21, 1970—April 21, 1971
I/AMA—CONTINUING EDUCATION COURSE; by Hahnemann; at Community General Hosp., once ea. month. Contact Paul K. Stolz, M.D., D.M.E., Community General Hosp., 135 N. Sixth Street, Reading 19601.

Sayre; August 24, 1970—June 14, 1971
I—ROTATING SEMINARS (10 sessions Cardiology; 5 sessions Dermatology; 11 sessions Endocrinology; 13 sessions Hematology; 7 sessions Neurology; 8 sessions Psychiatry; 4 sessions Radiation Therapy; 9 sessions Urology—Nephrology); at Robert Packer Hosp.; 1 hr. ea. session; hour-for-hour AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., Dir. Med. Educ., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Scranton; October 21, 1970—May 19, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Mercy Hosp.; 1 day a month; 8 months; 24 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Sellersville; September 23, 1970—June 16, 1971
I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann and Grandview Hosp.; at Grandview Hosp.; fourth Wed. ea. mo. (except December); 18 hrs. AAGP credit requested. Contact D. Henry Ruth, M.D., Dir. of Med. Educ., Grandview Hosp., Sellersville 18960.

Sewickley Valley Hospital; April 7—28, 1971
I—ANTIBIOTIC THERAPY; by Pitt and Sewickley Valley Hosp.; Wed. of ea. week. Contact Jerome Chamovitz, M.D., Sewickley Valley Hosp., Blackburn Rd., Sewickley 15143.

Sharon General Hospital; October 21, 1970—April 7, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES: first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Somerset Community Hospital; October 14, 1970—May 12, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; second Wed. ea. mo. except Jan. & Feb.; 18 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Tunkhannock; March 17—May 19, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program) by Educational and Scientific Trust of PMS; at Tyler Memorial Hospital; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Uniontown Hospital; October 14, 1970—March 24, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every other Wed., (except December); 30 AAGP credit applied for. $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wellsboro; March 17—May 19, 1971
I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Soldiers & Sailors Hosp.; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wilkes-Barre; March 31—May 26, 1971
I/AMA—CONTINUING EDUCATION COURSE; by Hahnemann; at Wyoming Valley Hosp.; Wednesday each week. Contact David W. Kistler, M.D., D.M.E., Wyoming Valley Hosp., 149 Dana St., Wilkes-Barre 18702.

Wilkes-Barre General Hospital; September 17, 1970—April 15, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; third Thurs. ea. mo.; 8 mos.; 3 hrs. AAGP credit approved for ea. session. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Williamsport Hosp.; September 11, 1970—March 12, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; second Fri. ea. mo. (except January); AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

INTERNAL MEDICINE

York Hospital; September 17, 1970—April 29, 1971
I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every Thurs.; 30 weeks; 3 hrs. AAGP credit approved ea. day; $40 fee ($8.00 single session). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Philadelphia; October 14, 1970—May 12, 1971
I/AMA—INTERNAL MEDICINE REVIEWS; by Hahnemann; at Alumni Hall; 3 hrs. a day; 1 day a week; 27 weeks; $150 fee ($70 per subspecialty); 81 hrs. AAGP credit approved. Contact Wilbur A. Oaks, M.D., Prog. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

MALIGNANT DISEASE

Johnstown; April 18 and May 6, 1971
I—CONTINUING EDUCATION PROGRAM (Cancer Subjects); by Western Pa. RMP; at Sunnehanna Country Club; 2 hrs. ea. day. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

Oil City Hospital; February 11—April 15, 1971
I—CONTINUING EDUCATION PROGRAM (Cancer Subjects); by Western Pa. RMP; second Thurs. ea. mo.; 2 hrs. ea. day. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

Philadelphia; September 9, 1970—June 23, 1971
I—CANCER DETECTION IN OFFICE PRACTICE; at American Oncologic Hosp.; 4 hrs. a day; 1 day a wk.; 20 hrs. AAGP

credit approved; course repeated every 5 weeks. Contact Joseph G. Strawitz, M.D., Assoc. Dir., American Oncologic Hosp., Central & Shelmire Aves., Philadelphia 19111.

Sharon General Hospital; February 19—June 18, 1971

I—CLINICAL PROBLEMS IN ONCOLOGY; by Western Pa. RMP; 2 hrs. ea. day; third Fri. ea. mo. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

Warren General Hospital; February 9—June 8, 1971

I—CONTINUING EDUCATION PROGRAM (Cancer Subjects); by Western Pa. RMP; second Tues. ea. mo.; 2 hrs. ea. day. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

Washington Hospital; February 17—May 19, 1971

I—CONTINUING EDUCATION PROGRAM; by Western Pa. RMP; third Wed. ea. mo., 2 hrs. ea. day. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

MICROBIOLOGY & IMMUNOLOGY

Allentown Hosp.; September 10, 1970—June 10, 1971

I—IMMUNOLOGY: BASIC CONCEPTS-CLINICAL APPLICATIONS (A Program of Continuing Medical Education; by Jefferson and Penn State; second Thurs. ea. mo.; 10 mos., 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc., Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

Danville; September 16, 1970—May 19, 1971

I—PSYCHIATRY AND COMMUNITY MENTAL HEALTH; by The Institute of Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. ea. day; 1 day a wk.; 10 weeks; 20 hrs. AAGP credit applied for. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Danville; September 24, 1970—May 27, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. per day; 1 day a week; 20 weeks; 40 hrs. AAGP credit applied for $25 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster Gen. Hosp.; February—April, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; 2 hrs. ea. day, 1 day ea. week; 20 weeks ea. semester; 40 hrs. AAGP credit applied for; $25 fee ea. semester. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Norristown State Hospital; March 5, 1971—May 21, 1971

I/S—FAMILY THERAPY; by Norristown State Hospital; 2 hrs. each day; one day each week; 10 weeks; $50 fee. Contact John D. Pruitt, M.D., Dir. Cont. Educ. for Psychiatrists, Norristown State Hospital, Stanbridge and Sterigere Sts., Norristown 19401.

Norristown; March—May, 1971

I—THE LATENCY AGE CHILD: by The Institute of the Pennsylvania Hosp.; at Montgomery Co. Mental Health Clinics, Inc.; 2 hr. a day; 1 day a week; 8 weeks; 16 hrs. AAGP credit applied for; $50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 8, 1970—April 6, 1971

I—MEDICAL HYPNOSIS; by the Institute of the Pennsylvania Hosp. and U. of Pa., Div. of Grad. Med.; at The Institute; 4 hrs. a day; 1 day a week; 20 weeks; 80 hrs. AAGP credit applied for; $150 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 21, 1970—June 2, 1971

I/AMA—SEMINARS IN PSYCHOTHERAPY; SHORT-TERM, CRISIS AND SUPPORTIVE THERAPIES; at Hahnemann; three 10-week seminars; every Wed.; 20 hrs. ea. seminar; AAGP credit requested; $75 fee for 10-week session, $150 for 30 sessions. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; January 7—March 25, 1971

I—TECHNIQUES OF CURRENT THERAPY IN THE MANAGEMENT OF MARITAL PROBLEMS, ADOLESCENT PROBLEMS AND CHRONIC COMPLAINERS; at The Institute of Penna. Hosp.; 3 hrs. a day; 1 day a week; 12 weeks; 36 hrs. AAGP credit applied for; $50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; February 23—March 30, 1971

I/TREATING TODAY'S ADOLESCENT; by Institute of Pa. Hosp. of U. of Pa.; at The Institute; 1½ hrs. a day; 1 day per week; 6 weeks. Fee $50. Contact J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; February 23—April 27, 1971

I/TREATING SEXUAL INCOMPATIBILITY; by Institute of Pa. Hosp. and U. of Pa.; at Marriage Council of Philadelphia; 2½ hrs. a day; 1 day per week; 10 weeks. Fee $50. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; February 22—March 29, 1971

I/PSYCHOPHARMACOLOGY; by Institute of Pa. Hosp. and Dept. of Psych. of U. of Pa.; at 111 N. 49th St.; 2 hrs. a day; 1 day a week; 6 weeks. Fee $50. Contact Gerald J. Margolis, M.D., Coordinator, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; April 7—May 12, 1971

I/AMA—DRUGS: PSYCHOTROPIC, PSYCHEDELIC AND ADDICTING; at Hahnemann; every Wed.; 6 weeks; 12 hrs. AAGP credit requested; $50 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; March 24—May 26, 1971

I/AMA—ADOLESCENCE AND THE YOUTH CULTURE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 10 hrs. AAGP credit requested; $75 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CONTINUOUS COURSES

Sessions of the following courses will convene continuously until completed.

ANESTHESIOLOGY

May 27—29, 1971; Pittsburgh

C/LIFE SUPPORT-MAJOR ORGAN SYSTEM FAILURES (Fifth Annual Symposium on Acute Medicine) by Amer. Soc. of Anesthesiologists; at Pittsburgh Hilton; $100 fee. Contact Bulent Kirimli, M.D., c/o Dept. of Anesthes., V.A. Hosp., Pittsburgh 15240.

CARDIOVASCULAR DISEASE

March 18—19, 1971; Philadelphia

C/AMA—HYPERLIPIDEMIA AND ATHEROSCLEROSIS; by U. of Pa.; at University Museum; 14 hrs. AAGP credit requested; $75 fee. Contact Office of Grad. Med. Educ., U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

March 29, 1971; Philadelphia

C—CARDIOPULMONARY RESUSCITATION INSTRUCTORS' TRAINING COURSE; for physicians, dentists, registered nurses and administrators; by Pa. Heart Assoc. of Southeastern Pa.; at Emergency Care Research Institute; $20 fee; limit - 30. Contact Emergency Care Research Institute, 913 Walnut St., Philadelphia 19107.

March 29—April 2, 1971; Philadelphia

C/AMA—CORONARY HEART DISEASE—CLINICAL MANIFESTATIONS AND TREATMENT FOR PHYSICIANS AND NURSES; by Hahnemann; at Marriott Motor Hotel; 30 hrs. AAGP credit requested; $125 fee. Contact William Likoff, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

May 6—7, 1971; Pittsburgh

C—EXPLORING SURGICAL TREATMENT FOR MYOCARDIAL INFARCTION; by Pa. Heart Assoc. (21st Annual Scientific Sessions); at Chatham Center; $25 fee (medical students, residents and interns free); $5 additional for ea. luncheon. Deadline for advance registration: April 22. Contact Pa. Heart Assoc., P.O.Box 2435, Harrisburg 17105.

July 19—21, 1971; Philadelphia

C/AMA—BEDSIDE DIAGNOSIS OF HEART DISEASE; by Hahnemann; at Marriott Motor Hotel; 7 hrs. ea. day; 21 hrs. AAGP credit requested; $125 fee. Contact Bernard L. Segal, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CHEST DISEASES

March 17, 1971; Reading Hospital

C—ENVIRONMENTAL LUNG DIS-

EASE; by Pa. Chapt. Amer. Coll. of Chest Physicians and Reading Hosp. Contact Mrs. Joan Hamilton, Reading Hosp., Reading 19602.

April 28—30, 1971; Philadelphia

C/AMA—RESPIRATORY INTENSIVE CARE UNIT; by U. of Pa.; at Annenberg Auditorium (on campus); 7 hrs. ea. day; 21 hrs. AAGP credit requested; $125 fee. Contact Office of Grad. Med. Educ., 288 Med. Labs. Bldg., Philadelphia 19104.

ENDOCRINOLOGY

March 1—26, 1971; Philadelphia

PG/AMA—ENDOCRINOLOGY (DIABETIC) TUTORIAL COURSE; at Hahnemann; 7 hrs. per day; 20 days; 140 hrs. AAGP credit requested; $100 per week. $350 entire course. Contact Mrs. Sage Cordell, Asst. Dir. Postgraduate Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

March 10, 1971; Sharon

C/AMA—MEDICAL AND SURGICAL ASPECTS OF THYROID DISEASE: by Jefferson and Penn State; 3 hrs. AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

FORENSIC MEDICINE

April 14, 1971; William Penn Hotel, Pittsburgh

O—MALPRACTICE IN THE EMERGENCY ROOM; by CES; 3 hrs. AAGP credit $5 fee. Contact Comm. on Emerg. Med. Serv., Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pa. 17043.

GENERAL MEDICINE

March 12, 1971; Hershey Medical Center

C—SELECTED TOPICS FOR EMERGENCY ROOM CARE; by Pa. Committee on Trauma of Amer. Coll. of Surgeons and Pa. Nurses' Assoc.; AAGP credit requested; registration limited to 150; $7.50 fee (includes luncheon), payable to Pa. Committee on Trauma, A.C.S. Contact W. E. DeMuth, M.D., Chrm., 17 S. West St., Carlisle 17013.

April 3, 1971; Harrisburg

C—DIABETES; by CES and Pa. Osteopathic Assoc.; at Holiday Inn Town; 6 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

As Requested, 1971; Philadelphia

PG—ACUTE CARE MEDICINE FELLOWSHIP (retraining program for women physicians); by Woman's; 6 hrs. per day; 1 yr. duration. Contact Ethel Weinberg, M.D., Assoc. Dean, Woman's, 3300 Henry Ave., Philadelphia 19129.

INTERNAL MEDICINE

March 22—23, 1971; Philadelphia

C/AMA—SMALL BOWEL; by U. of Pa.; at Grad. Hosp. of U. of Pa.; 14 hrs. AAGP credit requested; $75 fee. Contact Office of Grad. Med. Educ., 288 Med. Labs. Bldg., Philadelphia 19104.

May 19-21, 1971; Philadelphia

C/AMA—PATHOPHYSIOLOGY OF PULMONARY DISEASE; by U. of Pa.; at Annenberg Center of Communications; 7 hrs. ea. day; 21 hrs. AAGP credit requested; $125 fee. Contact Office of Grad. Med. Educ., U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

MALIGNANT DISEASE

March 26, 1971; Franklin Hospital

C—CANCER OF THE PROSTATE; by Western Pa. RMP; 2 hrs. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

NEUROLOGY

May 26-28, 1971; Philadelphia

C/AMA—NEWER ASPECTS OF NEUROLOGY AND NEUROSURGERY; by U. of Pa.; at Hospital of U. of Pa., 7 hrs. ea. day; 21 hrs. AAGP credit requested; $100 fee. Contact Office of Grad. Med. Educ., 288 Med. Labs. Bldg., Philadelphia 19104.

OBSTETRICS & GYNECOLOGY

April 15, 1971; Hershey Motor Lodge

C—12TH ANNUAL MATERNAL & CHILD HEALTH INSTITUTE; by CES and Pa. Dept. of Health; $10 fee; 4 hrs. AAGP credit applied for. Contact Comm. on Maternal & Child Health, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

OPHTHALMOLOGY

April 28-30, 1971; Pittsburgh

C/S—OPHTHALMOLOGIC MICRO-SURGERY; by Pitt; at Eye and Ear Hospital; 24 hrs.; $400 fee. 20 limit. Contact Kenneth T. Richardson, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

May 5-7, 1971; Pittsburgh

C/S—STRABISMUS (A Comprehensive Symposium in Diagnosis and Treatment); by Pitt; at Eye and Ear Hospital; 24 hrs.; $200 fee; 20 limit. Contact David A. Hiles, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

August 2—6, 1971; Pittsburgh

C/S—THE MANAGEMENT OF RETINAL DETACHMENT; by Pitt.; at Eye & Ear Hosp.; 8 hrs. ea. day; 5 days; $300 fee. Contact William G. Everett, M.D., Dir., Eye & Ear Hosp., 230 Lathrop St., Pittsburgh 15213.

OTOLARYNGOLOGY

April 1-2, 1971; Philadelphia

C/AMA—THERAPY IN OTOLARYNGOLOGY; 1971 (Postgraduate symposium); by Jefferson; $50 fee ($10 to residents). includes luncheon both days and one dinner. Contact William Baltzell, M.D., Dept. of Otol., Jefferson, 1025 Walnut St., Philadelphia 19107.

April 26—May 7, 1971; Philadelphia

C/AMA—PRACTICAL COURSE IN BRONCHO-ESOPHAGOLOGY; by U. of Pa.; at Grad. Hosp. of U. of Pa., 7 hrs. ea. day; 70 hrs. AAGP credit requested; $250 fee. Contact Office of Grad. Med. Educ., U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

PEDIATRICS

March 29—April 2, 1971; Philadelphia

C/AMA—A FIVE-DAY REFRESHER COURSE FOR PEDIATRICIANS AND GENERAL PRACTITIONERS; by U. of Pa.; at Children's Hosp.; 27 hrs. AAGP credit approved; $185 fee. Contact F.B. Becker, M.D., Chrm., Post Grad. Educ. Committee, 1740 Bainbridge St., Philadelphia 19146.

May 5—7, 1971; Philadelphia

C/AMA—BRONCHIAL AND ESOPHAGEAL DISEASE IN INFANCY AND CHILDHOOD; by U. of Pa.; at Grad. Hosp. U. of Pa.; 21 hrs. AAGP credit requested; $75 fee. Contact Office of Grad. Med. Educ., U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

May 11—14, 1971; Philadelphia

C—TWENTIETH ANNUAL SEMINAR IN PEDIATRICS; by Temple; at St. Christopher's Hosp., for Children; 28 hrs. AAGP credit requested; $100 fee. Contact John B. Bartram, M.D., St. Christopher's Hosp. for Children, 2600 N. Lawrence St., Philadelphia 19133.

March 31, 1971; Philadelphia

C/AMA—PUBLIC EDUCATION AND THE MENTAL HEALTH SCIENCES; by Hahnemann; at Holiday Inn; 8 hrs.; $35 fee. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

SURGERY

March 29—April 2, 1971; Philadelphia

C/AMA—MAXILLOFACIAL ANATOMY AND SURGERY; by U. of Pa.; 7 hrs. ea. day; 35 hrs. AAGP credit requested; $175 fee ($100-anatomy only; $100-surgery only). Contact Office of Grad. Med. Educ., U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

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obituaries

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **William J. Goetz,** Elizabethtown; Jefferson Medical College, 1913; age 80; died October 29, 1970. He was a past president of the Berks County Medical Society. Dr. Goetz, a cardiologist, was among the first class of fellows chosen by the American College of Cardiology in 1951 and in 1957 he was named a fellow of the American College of Chest Physicians, the highest honor a heart specialist can receive. He is survived by his wife and a stepdaughter.

○ **Harry S. Good,** Womelsdorf; University of Rochester School of Medicine and Dentistry, 1934; age 61; died November 16, 1970. Dr. Good had been a member of the staff of Reading Hospital since 1935 while maintaining his private practice until 1967 when he became associated with Wernersville State Hospital. Surviving are his wife, a son and daughter, a brother and a sister.

○ **John C. Kelly,** McKeesport; University of Pittsburgh School of Medicine, 1910; age 88; died November 12, 1970. Until his death Dr. Kelly remained an active civic leader, sportsman and physician. He is survived by a son and a brother.

○ **Violet H. Kidd,** Zelienople; Hahnemann Medical College, 1936; age 59; died November 3, 1970. Dr. Kidd was medical director of the Lutheran Old Peoples Home in Zelienople. She was known for her work in geriatrics. She is survived by her husband, Paul School, M.D., and two daughters.

○ **James W. Levering,** Jenkintown; University of Pennsylvania School of Medicine, 1914; age 79; died October 26, 1970. Dr. Levering, a surgeon, had been affiliated for nearly fifty years with Abington Hospital before retiring in 1963. His wife, a son, a daughter and a sister survive.

○ **Edward V. Ocelus,** Bridgeport; Temple University School of Medicine, 1938; age 58; died November 12, 1970. Dr. Ocelus served in the Army Medical Corps during World War II. Survivors include his wife, two daughters, three sons, a sister and two brothers.

○ **Joseph A. Perrone,** Pittsburgh; University of Pittsburgh School of Medicine, 1928; age 64; died November 7, 1970. Dr. Perrone, a pioneer in the field of bronchology, performed the first laryngectomy in Pittsburgh. His wife, three daughters, five brothers and a sister survive.

○ **Francis X. Bauer,** Natrona Heights; Jefferson Medical College, 1940; age 57; died November 7, 1970. Since 1950 Dr. Bauer had served as a surgeon in Allegheny Valley Hospital, Natrona Heights and Citizens General Hospital. His wife, three daughters, four sons and his mother survive.

○ **Clarence E. Baxter,** Coudersport; Hahnemann Medical College, 1938; age 60; died October 26, 1970. During 1970 he had served as president of the Potter County Medical Society. Surviving are his wife, a son and a daughter.

○ **Dorothy C. Blechschmidt,** Riverside, Calif.; The Medical College of Pennsylvania, 1907; age 85; died October 31, 1970. She was former chief of general surgery at both the Doctor's Hospital and the former Woman's Hospital of Philadelphia. Dr. Blechschmidt was the founder and chief of staff of the Cancer and Health Clinic at Doctor's Hospital which was named in her honor. Five grandchildren survive.

○ **Chalmers E. Cornelius,** Jenkintown; University of Pennsylvania School of Medicine, 1926; age 68; died November 25, 1970. Dr. Cornelius was the chief of the otolaryngological services at Abington Hospital until his retirement in 1964. He was also an associate professor of medicine at the University of Pennsylvania's Graduate School of Medicine. Survivors include his wife, a son, two daughters and a sister.

○ **Joseph C. Fulmer,** Deland, Fla.; Jefferson Medical College, 1910; age 85; died May 25, 1970. No survivors are listed.

○ **John A. Schoff,** Norristown; University of Pennsylvania School of Medicine, 1935; age 63; died August 4, 1970. Two sons survive.

○ **Francis E. Wiedmann,** Philadelphia; Jefferson Medical College, 1952; age 44; died October 28, 1970. Dr. Wiedmann was a pathologist at the Albert Einstein Medical Center, northern division, for ten years. He is survived by his wife, two daughters, his mother, three brothers and two sisters.

Harold H. Morris, St. Simons Island, Ga.; University of Pennsylvania School of Medicine, 1908; age 86; died December 17, 1970. After serving as a medical missionary in China for thirty-eight years he returned to Philadelphia to join the staff of the Pennsylvania Hospital. He is survived by his wife, two sons, Harold H. Morris, Jr., M.D. and C. C. Morris, M.D., two daughters, a sister and a brother.

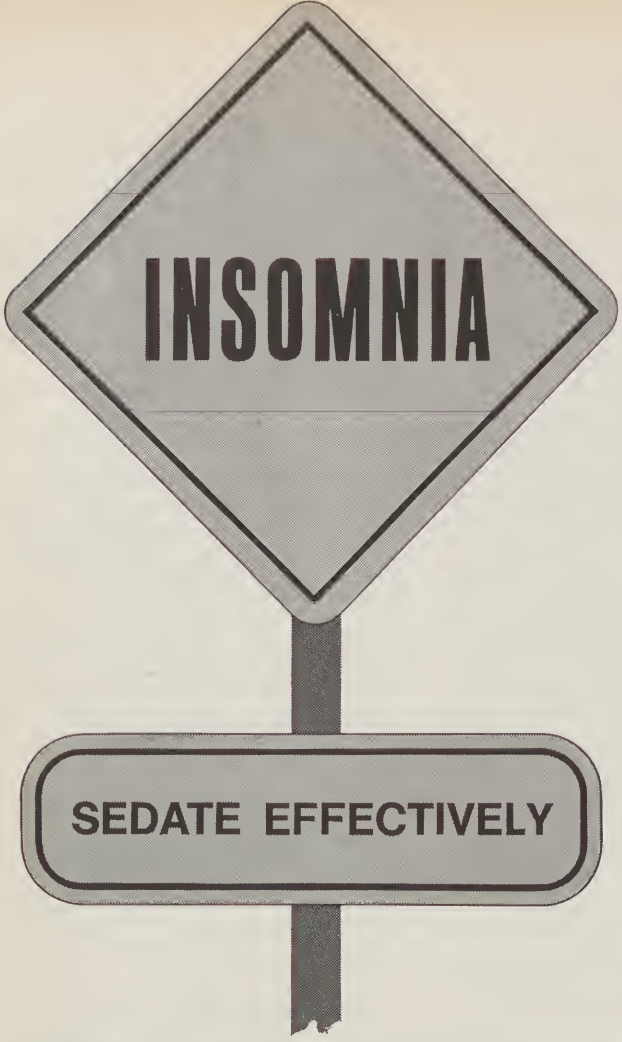
M. Rozella Popp, New Castle; Loyola University Stritch School of Medicine, Chicago, 1927; age 76; died October 4, 1970. A sister survives.

F. Willis Smith, Levittown; George Washington University School of Medicine, 1938; age 60; died January 5, 1970. His wife survives.

Hugh T. Bigg, Jamestown, N.Y.; McGill University, 1949; age 52; died November 7, 1970. He recently assumed duties with the Family Guidance Clinic in Sharon while maintaining his private practice in Jamestown. Survivors include his wife and five children.

Modestus W. Buechele, Altoona; Jefferson Medical College, 1926; age 70; died August 3, 1970. A sister survives.

Oscar B. Griggs, Camp Hill, Hahnemann Medical College and Hospital, 1933; age 61; died December 15, 1970. He was employed by the Pennsylvania State Department of Health in the division of chronic respiratory diseases. Surviving are his wife, Sara Mercer Griggs, M.D., two daughters and a son.



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econd Annual Workshop sponsored by the Western Pennsylvania Institute of Alcohol Studies, **April 18-23, 1971,** University of Pittsburgh, Pittsburgh. For information contact: Western Pennsylvania Institute of Alcohol Studies, Department of Special Education and Rehabilitation, University of Pittsburgh, Pittsburgh, 15213.

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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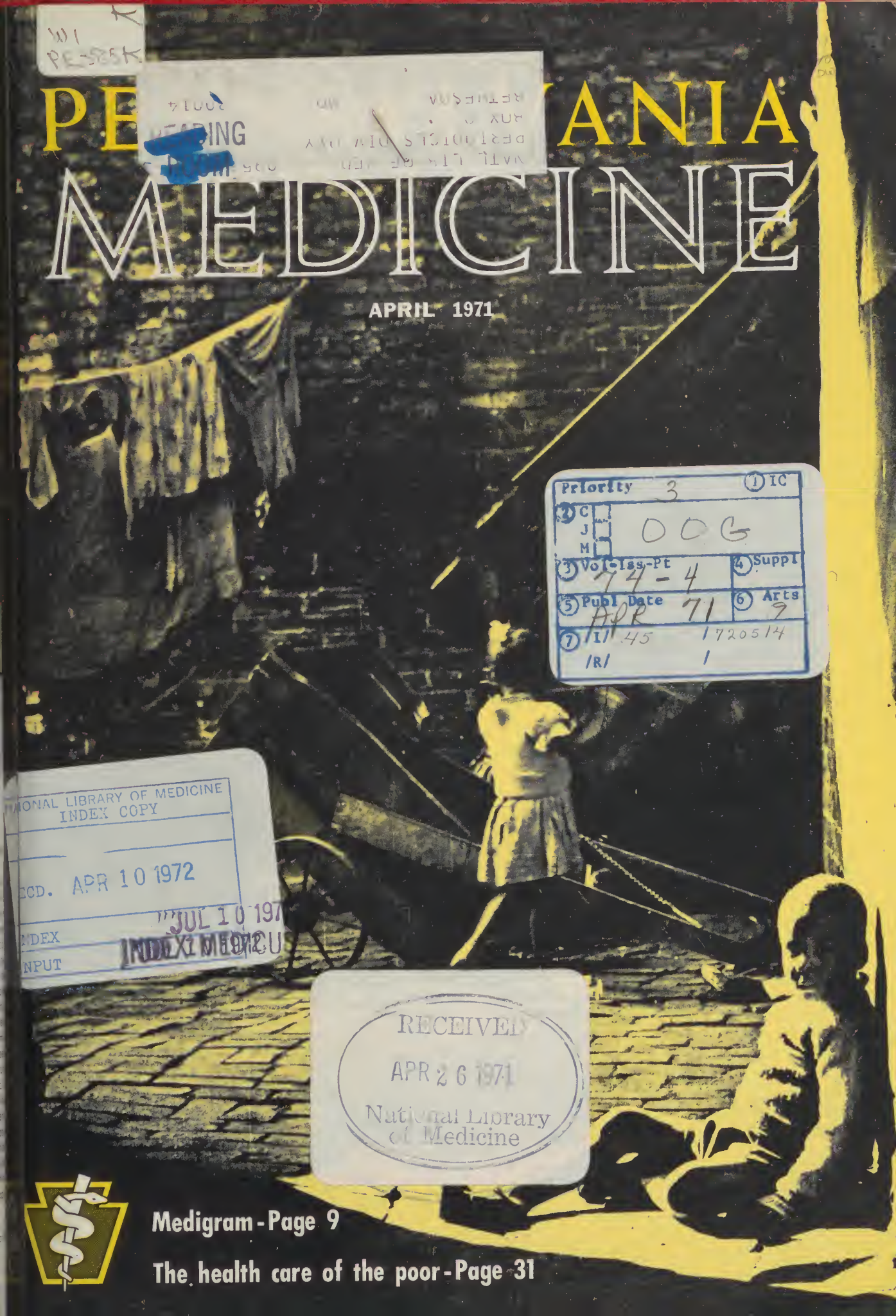

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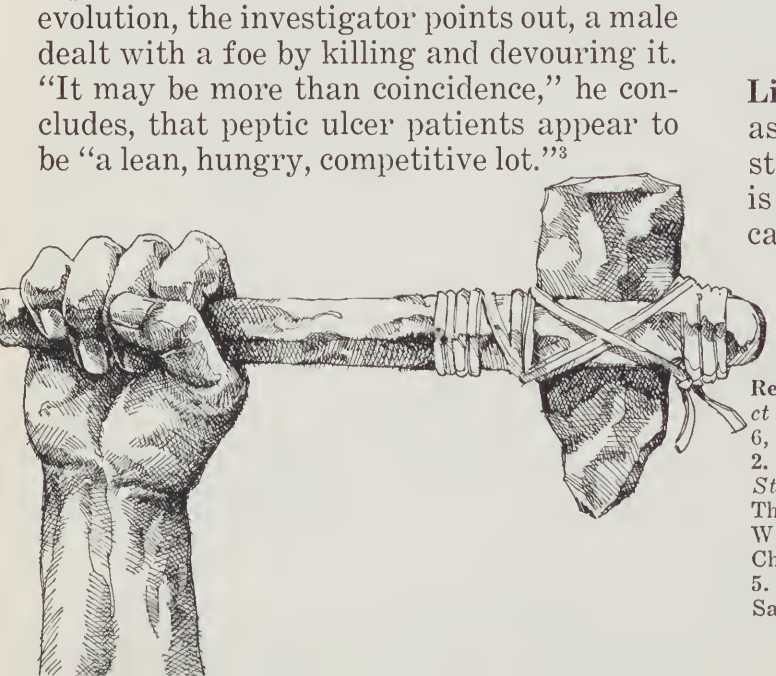
The health care of the poor - Page 31

IF MORE MEN CRIED

At least seventy-five out of one hundred adults with duodenal ulcers are men.[1] Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."[2]

Hypersecretion—an atavistic response. Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."[2]

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."[3]

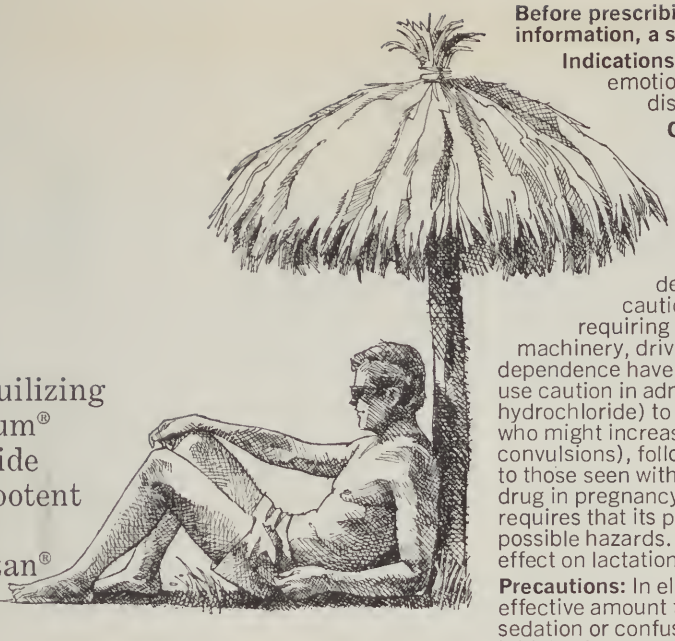


Big boys don't cry. If more men cried, maybe fewer would wind up with duodenal ulcers. But men will be men—the sum total of their genes and what they are taught. Schottstaedt observes that when a mother admonishes her son who has hurt himself that big boys don't cry, she is teaching him stoicism.[4] Crying is the negation of everything society thinks of as manly. A boy starts defending his manhood at an early age.

Take away stress, you can take away symptoms. There is no question that stress plays a role in the etiology of duodenal ulcer. Alvarez[5] observes that many a man with an ulcer loses his symptoms the day he shuts up the office and starts out on a vacation. The problem is, the type of man likely to have an ulcer is the type least likely to take long vacations or take it easy at work.

The rest cure vs. the two-way action of Librax.® For most patients, the rest cure is as unrealistic as it is desirable. Still, the stress factor must be dealt with. And here is where the dual action of adjunctive Librax can help. Librax is the only drug that com-

References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, M. M., *et al.* (eds.): *Harrison's Principles of Internal Medicine*, ed. 6, New York, McGraw-Hill Book Company, 1970, p. 1444. 2. Wolf, S., and Goodell, H. (eds.): *Harold G. Wolff's Stress and Disease*, ed. 2, Springfield, Ill., Charles C Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schottstaedt, W. W.: *Psychophysiologic Approach in Medical Practice*, Chicago, Ill., The Year Book Publishers, Inc., 1960, p. 163. 5. Alvarez, W. C.: *The Neuroses*, Philadelphia, Pa., W. B. Saunders Company, 1951, p. 384.



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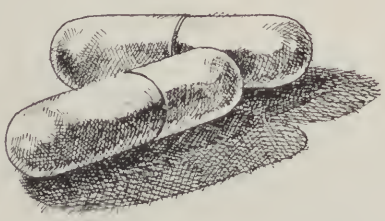

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Indications: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

in the treatment of duodenal ulcer adjunctive

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Journal of the Pennsylvania Medical Society

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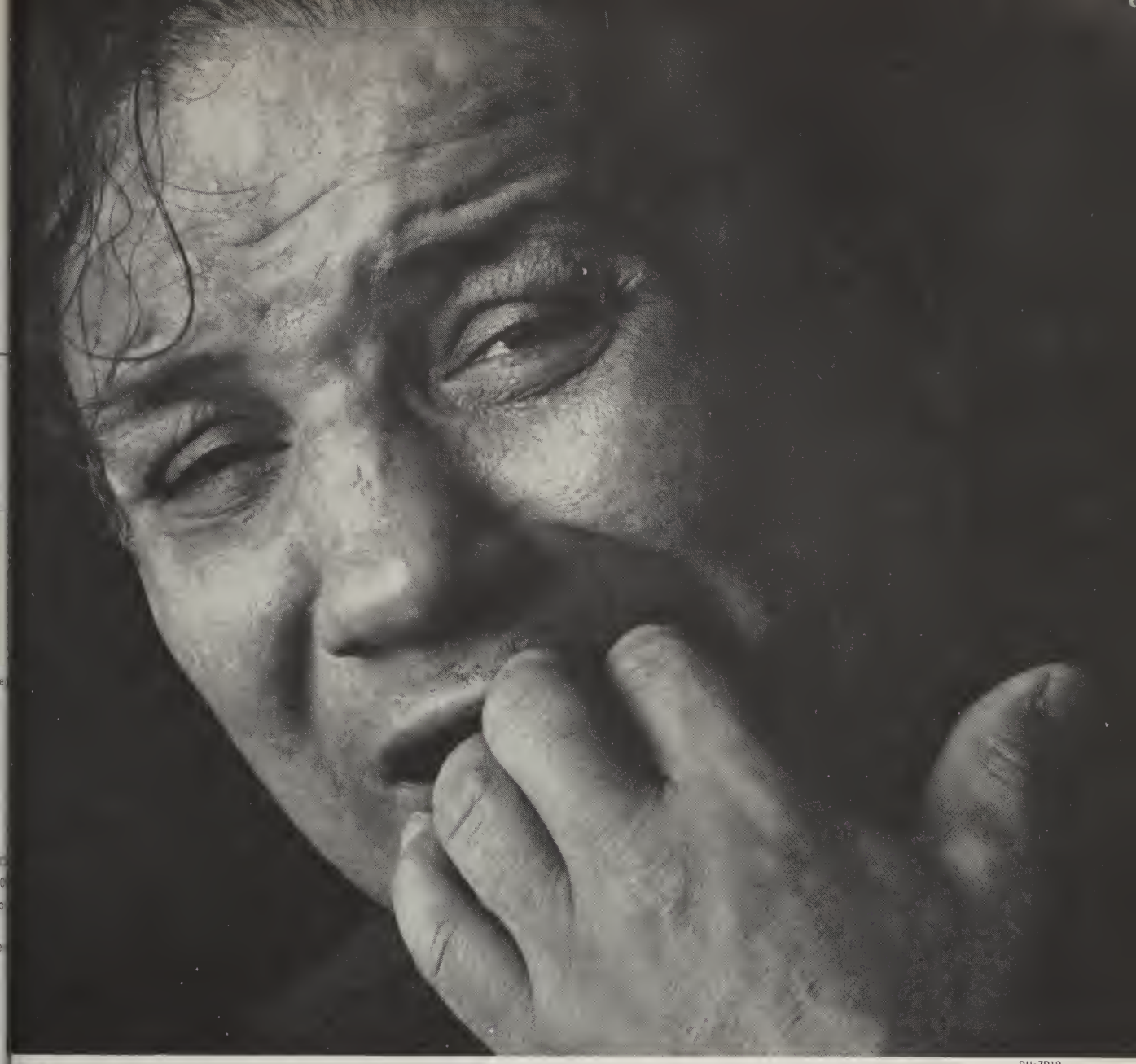

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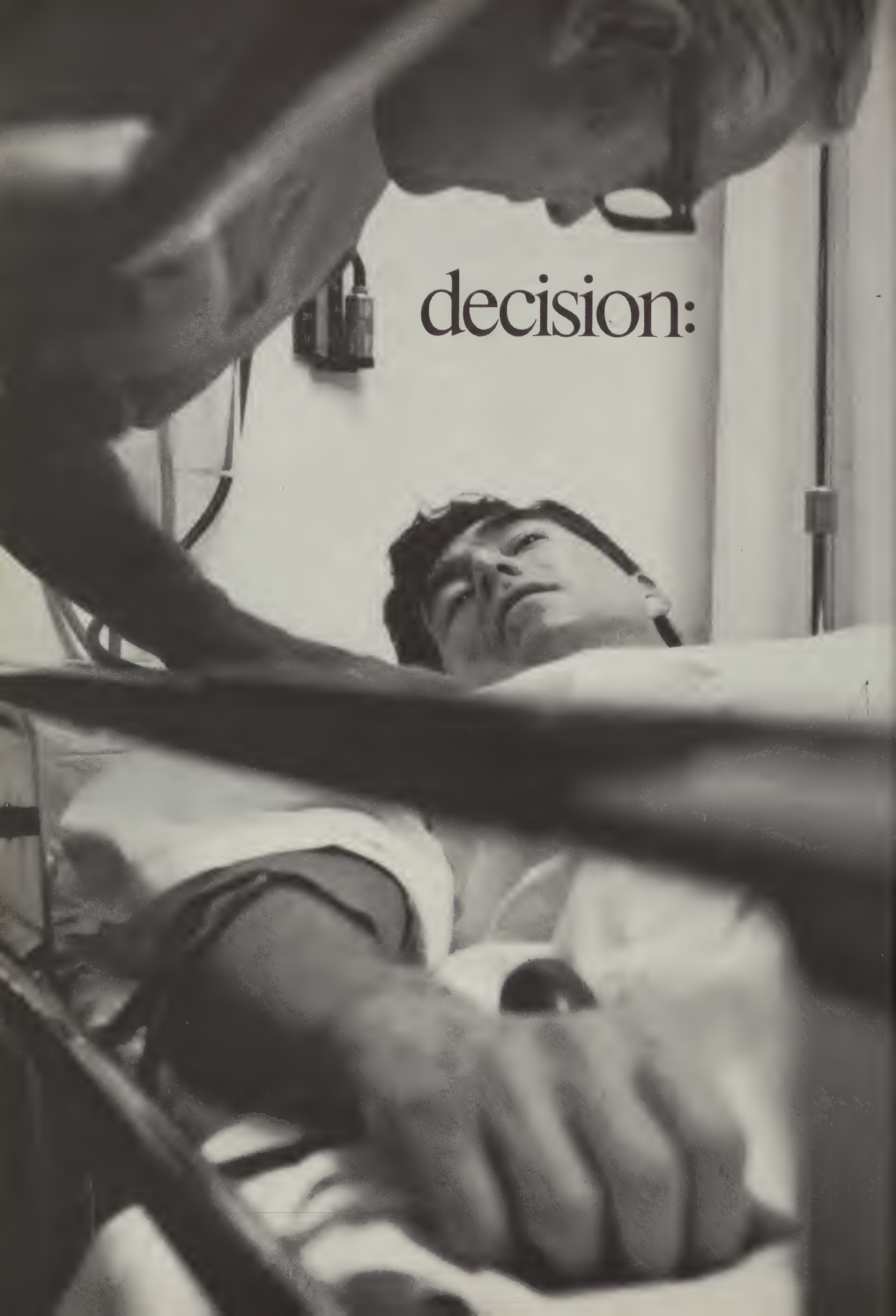
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*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

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Loridine®
CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169]

Additional information available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly

000904

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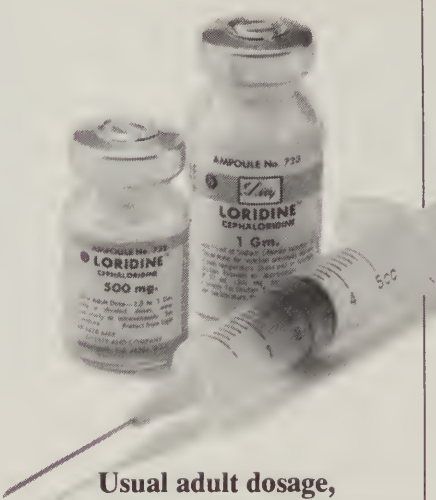

Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

hyperpHaze delivers more effective antibacterial action than the leading antibacterial bar soap or liquid skin cleanser.*

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Before prescribing, please consult complete product information, a summary of which follows:

INDICATION: Relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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PENNSYLVANIA MEDICINE medigram APRIL 1971

M.D.-Guided Group Malpractice Plan Approved

The PMS Board of Trustees has approved a plan for professional liability insurance coverage for State Society members with a history-making degree of physician control over coverage decisions. The contract is with a top-rated insurance carrier, Argonaut Insurance Co. of California, for a guaranteed five-year minimum. Rates are guaranteed not to exceed other rates for similar coverage and may be less. Administrator will be the brokerage firm of Parker and Co. of Pennsylvania. Details will be in a letter this month from PMS President William A. Limberger, M.D., to each PMS member and will appear in the next issue of PENNSYLVANIA MEDICINE. The unique feature of the plan provides for physician review of the carrier's financial records involving the group coverage and physician participation through a PMS commission and district committees of underwriting decisions in individual cases. Effective target date is June 1 but coverage consideration is available immediately for those whose renewal occurs before June 1 or for those with immediate coverage problems. The contact--A. John Smither, vice-president of Parker and Co., by telephoning (215) 545--1700. The action follows years of study by the PMS Council on Medical Service and encouragement from the House of Delegates.

FOUNDATION INCORPORATION FILING APPROVED With a bill pending in the legislature that would affect the structure of health care foundations, the PMS Board of Trustees has approved articles of incorporation of the Pennsylvania Medical Care Foundation and has directed legal counsel to file them. The House of Delegates approved the foundation in principle and will have the chance to review the incorporation articles this fall. The filing was to allow for a possible advantage under existing law and to give the House the opportunity to consider that advantage. The foundation would have a potential for administering health maintenance and other pre-payment plans, for contracting with government for medicare and medicaid, "Pennsycare," and for developing peer review functions. The Board named members of the PMS Subcommittee on Medicare Care Foundation as the incorporators and interim directors. They are: Robert P. Dutlinger, M.D., Harrisburg; Robert B. Edmiston, M.D., Harrisburg; John Helwig, Jr., M.D., Philadelphia; Matthew Marshall, Jr., M.D., Pittsburgh; George R. Moffitt, Jr., M.D., Harrisburg; William G. Ridgway, M.D., Akron; and Robert A. Schein, M.D., Pittsburgh. The June issue of PENNSYLVANIA MEDICINE will carry details.

PMS OFFICIALS TESTIFY AT BLUE CROSS HEARINGS PMS President William A. Limberger, M.D., and Matthew Marshall, Jr., M.D., Pittsburgh, chairman of the Subcommittee on Medical Care Foundation, testified at a hearing of the Pennsylvania Insurance Commission in Philadelphia on a request for a rate increase of 50 per cent by Philadelphia Blue Cross. The occasion marked the first public explanation of the PMS plan for a Medical Care Foundation to assist in controlling the cost, quality and quantity of health and medical care for all state residents. Despite orders by Dr. Herbert S. Denenberg, insurance commissioner of the Commonwealth, to hospitals in the Philadelphia area to cut costs, he indicated following the hearings that the requested rate increase probably would be granted.

OTHER MARCH BOARD ACTIONS The PMS Board has: Voted unanimously to reiterate to the new Commonwealth administration the PMS position that all matters relating to the health of the residents should be under the aegis of the Department of Health... Moved to submit names of possible replacements on the Drug, Device and Cosmetic Board for George E. Farrar, Jr., M.D., who has left the state ...Approved a "white paper" on emergency medical services as recommended by the Council on Education and Science, and authorized its publication...Viewed the hour-long TV documentary prepared by the Council on Public Service, entitled "Health Care--the Coming Crisis"...Nominated for the AMA Sheen Award John H. Gibbon, Jr., M.D., Philadelphia, who perfected the heart-lung machine...Heard the report of William J. Kelly, M.D., Pittsburgh, PMS representative to the State Board of Medical Education and Licensure, that rewriting of the medical practice act has been completed, and may be introduced in the Legislature soon. Moved to rename the Advisory Committee to the Executive Director. It will be called the Executive Committee, "invested with the appropriate authority implicit in its name, specifically the authority to take policy action on behalf of the Board of Trustees between meetings of the Board when this is necessary." The action is subject to approval of the 1971 House of Delegates.

COUNCIL PLANS D.C. VISIT The Council on Governmental Relations has scheduled its annual congressional visit to Washington, D.C., chairman Edgar W. Meiser, M.D., Lancaster, has announced. Selected physicians will visit their representatives and senators to discuss the Society's position on federal legislation. AMA staff members will explain various proposals for national health insurance, particularly the status of the AMA's "Medicredit" proposal, on which committee hearings have begun.

NEW APPOINTMENTS MADE The Board of Trustees approved the appointments of Roland A. Loeb, M.D., Lancaster, to the Council on Education and Science; and Dominic A. Donio, M.D., Allentown, delegate and Herman Rudolph, M.D., Reading, alternate delegate, from the Pennsylvania Academy of Physical Medicine and Rehabilitation, to the Society's Interspecialty Committee.

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40-44	10,000	63.50
45-49	5,000	51.85
50-54	5,000	77.00
55-59	5,000	115.15

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You are hereby authorized to give The Travelers Insurance Company any and all information you may have regarding my condition when under observation or treatment by you including the history obtained, findings and diagnosis. Photographic copy of this authorization is to be considered acceptable. This is a personal request from me and your cooperation will be appreciated.

_____ 19 _____

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Signature of Proposed Insured

AGENT'S CERTIFICATE

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(If "yes," give details, full name of company, and state all other life insurance now in force on the life of the proposed insured.)

Signed _____
Agent or Broker

Date _____

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1. PROPOSED INSURED *(Print full name)* | SEX | Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( )

2. BENEFICIARY *Name and Relationship*

3. DATE OF BIRTH Month Day Year | AGE NEAREST BIRTHDAY | PLACE OF BIRTH | CITIZEN OF

4. AMOUNT OF INSURANCE $

5. FORM SWT TERM with AIP

IS PREMIUM WAIVER FOR DISABILITY DESIRED? YES [X] NO [ ]

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7. Will this insurance replace any existing life insurance? If "yes" give details and full name of company.

The right to change the beneficiary is reserved.

Unless otherwise indicated, payment due two or more beneficiaries shall be in equal shares and to the survivors or survivor of them.

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9. NAME OF EMPLOYER AND ADDRESS *(Employer)* *(Street and Number)* *(City and Zone)* *(State)*

10. Have you flown within 5 years as a pilot, student pilot or crew member on any aircraft, or as a passenger on other than a scheduled airline, or do you expect to make such flights? *(If "yes," give details)*

11. OCCUPATION—*Title or duties*

12. Have you ever been told by a physician or practitioner that you had, or have you been treated by a physician or practitioner for:

a. Arthritis, rheumatism, gout or neuritis; mental or nervous disorder? Yes [ ] No [ ]

b. Asthma, pleurisy, tuberculosis, lung disease, anemia or goiter? Yes [ ] No [ ]

c. Heart trouble, chest pain, angina, heart murmurs or high blood pressure? Yes [ ] No [ ]

d. Cancer, tumors, cysts or growths? Yes [ ] No [ ]

e. Diabetes, or albumin, sugar or pus in urine? Yes [ ] No [ ]

f. Disease or disorder of stomach, intestines, liver, or kidneys? Yes [ ] No [ ]

13. Were you ever a patient in a hospital, clinic or sanitarium for examinations or treatment? Yes [ ] No [ ]

14. Have you had health examinations or medical checkup in the past 5 years? Yes [ ] No [ ]

15. Have you been postponed, rated, or declined for life, accident or sickness insurance in the past 5 years? Yes [ ] No [ ]

16. Do you now have, or have you had in the past 5 years any other sickness or injury not referred to in Question 12? Yes [ ] No [ ]

17. Height in shoes ft.____ in.____ Weight in clothes____lbs.

18. Please explain all "Yes" answers to questions 12 through 17 above, giving full details below:

Question No.	Illness or Condition	Give Dates From	Give Dates To	Give Full Name and Address of All Physicians or Practitioners Consulted

19. FOR HOME OFFICE INDORSEMENT ONLY

I am presently in full time active practice and not retired for reasons of health.

20. PROPOSED INSURED UNDERSTANDS AND AGREES THAT:

1. Part 1 and Part 2, if required, of this application and any supplements thereto shall form the basis for and be a part of any contract of insurance issued on this application, and that all statements and answers in Part 1 and Part 2, if required, of this application and any supplements thereto are complete and true to the best of his knowledge and belief.
2. No insurance shall take effect until the contract is delivered to Proposed Insured and the first premium paid in full all while the Proposed Insured's health and other conditions relating to insurability remain as described in this application.
3. No agent is authorized to make, alter, or discharge any contract; to waive or change any condition or provision of any contract, application, or receipt; to accept any risk, or to pass upon insurability.
4. Acceptance of any contract issued on this application shall constitute ratification of any corrections, additions, or changes made by the Company and noted in the space provided "For Home Office Indorsement Only," except where written consent is required by law.
5. The Proposed Insured shall be the Applicant and owner of any contract issued on this application.

DATED_____ 19____ AT_____
(City or Town, State)

PROPOSED INSURED_____
(Signature in full)

WITNESSED BY_____

Society officers meet in annual conference

Medicine in the seventies —quality control, financing and delivery of medical care—is the theme of this year's meeting of state and county medical society officials at the annual PMS Officers' Conference, April 28 and 29 at the Penn Harris Motor Inn, Camp Hill.

The keynote address on the financing of health care will be delivered by William A. Limberger, M.D., PMS president. A panel discussion on various health care plans in existence in other countries will follow. Panel members will include a representative of the Canadian Medical Association; George Dunlop, M.D., president of Massachusetts Blue Shield; and Horace Cotton, president of Horace Cotton Associates and president of the National Association of Business Consultants.

The chairman of the PMS Subcommittee on Medical Care Foundation, Matthew Marshall, M.D., Pittsburgh, and Donald C. Harrington, M.D., medical director of San Joaquin Medical Care Foundation, California, will discuss and answer questions regarding the Pennsylvania Medical Care Foundation.

The chairman of the PMS Officers' Conference Committee, Orlo G. McCoy, M.D., Canton, will preside over the entire session. Thursday morning's general session is entitled "Quality Control in Pennsylvania Medicine." Robert L. Evans, M.D., vice-president of medical affairs at York Hospital, and Rutledge Howard, M.D., Chicago, of the continuing education department of the American Medical Association, will discuss continuing education requirements of PMA—the reasons for it and an analysis of what it is.

Norman Sterns, M.D., director of the Postgraduate Medical Institute of Boston, serving the Massachusetts Medical Society, and John H. Moyer, M.D., chairman of the department of medicine at Hahnemann Medical College, will explain the PMS Continuing Education Institute. A discussion, "Peer Review for Quality Control," which will consider a plan already in existence, will conclude the morning's deliberations.

Park M. Horton, M.D., New Milford, chairman of the PMS Board of Trustees and Councilors, will preside at the Thursday luncheon.

DR. DUNLOP

DR. HOWARD

DR. STEARNS

DR. HARRINGTON

Public press makes known malpractice dilemma

The public press is becoming more aware of the rising incidence of malpractice suits against physicians. A recent supplement of *The Philadelphia Sunday Bulletin* carried an article on the subject. It indicates that in Canada malpractice suits are rare largely because lawyers consider it unethical to accept clients on a contingency basis, whereas in the United States lawyers are regularly agreeing to take cases on a split-fee basis.

The Bulletin lists this as one reason why malpractice suits in America against doctors are reaching crisis proportions, with some awards running as high as a million dollars. As a direct result of this fact, insurance companies hiked the cost of insurance 65 per cent last year.

In order to avoid liabilities, doctors are prescribing countless x-rays and tests, and they are hospitalizing patients longer than necessary, causing increases in costs.

This article says that the most common causes of suits, according to Mary C. McLaughlin, M.D. of the New York City Health Commission, are (1) a foreign body left in a patient during surgery (2) bad effects from too-tight casts (3) technical surgical errors (4) lack of informed consent (5) errors made by residents, interns or nurses (6) adverse reactions to penicillin or tetanus shots (7) abandonment of obstetric patients (8) burns from x-rays or chemicals (9) failure to properly attend a surgical cardiac arrest.

The suggestion is made that one way to free doctors and patients from the worry of suits would be a low-cost, no-fault insurance system, which could be provided as part of the patient's daily room rate.

Dr. Farrar retires from Wyeth

George E. Farrar, Jr., M.D., director of medical services at Wyeth Laboratories, Radnor, Pa., has retired after thirty years' service with the firm. He is a past president of the Pennsylvania Medical Society.

Dr. Farrar has been a leading figure in the fields of medicine and education as well as business for many years.

DR. FARRAR

From 1949 to 1962 he was medical director at Wyeth, after serving as consultant to the firm's advertising department from 1940. He was appointed medical services director in 1962, representing Wyeth in its relations with organized medical groups, societies and schools.

In 1936 Dr. Farrar became assistant professor of medicine and chief of the hematology clinic at Temple University School of Medicine and Hospital, becoming associate professor in 1944.

During World War II, he organized personnel and facilities in the Philadelphia area for a physical therapy technicians' course for U.S. Navy Corpsmen. Since 1950 he has been a member of the Committee of Revision of the *U.S. Pharmacopeia*, and in 1970 was elected vice-president.

Dr. Farrar is president of United Health Services, a United Fund agency in Philadelphia; and is a past president of the Philadelphia County Medical Society.

Following retirement, Dr. Farrar will serve as a field representative for the Joint Commission on Accreditation of Hospitals, a group formed to ensure the quality of American hospitals and hospital care. Its board is comprised of members of the American Hospital Association, the American Medical Association, the American College of Surgeons and the American College of Physicians.

Milbank funds study

L.E. Burney, M.D., executive director of the Milbank Memorial Fund, has announced an award of $9,800 to the American College of Preventive Medicine for a conference on public health residency training to be held in Haverford May 13 and 14. Other grants awarded to the American College of Preventive Medicine include a Merck Foundation award of $10,000 "in support of the College's program for development of new approaches toward delivery of medical services," and an award of $1,000 by Smith, Kline, and French Laboratories "in support of college programs."

GEORGE A. HAHN, M.D., President of the Philadelphia County Medical Society accepts a check for $500 from Mrs. Richard A. Brunner, president of the society's woman's auxiliary. The money is for S.S. Hope a volunteer project for Dr. Hahn, who spends a month on Hope every year. The money was raised by the auxiliary at its annual fall benefit, a luncheon and fashion show. In presenting the check, Mrs. Brunner said "We honor Dr. Hahn and all doctors whom we recognize and remember with pride for their distinguished service to S.S. Hope."

New department formed at Pittsburgh hospital

A department of maxillofacial prosthetics established by the board of directors of the Eye and Ear Hospital of Pittsburgh is the eighth such facility in the U.S. It will be directed by Bernard W. Segall, D.M.D., who is on the faculty of Schools of Medicine and Dental Medicine at the University of Pittsburgh. Funds have been provided by the Sara Mellon Scaife Foundation for this public service.

Preliminary Call to the 1971 Annual Session of the House of Delegates

The 1971 Annual Session of the House of Delegates of the Pennsylvania Medical Society will be called to order in Ballroom One of the Pittsburgh Hilton at 7:30 p.m., Monday, October 4, 1971. The second and concluding meeting of the House of Delegates is scheduled for Wednesday, October 6, 1971 at 9:00 a.m.

All proposed amendments to the Constitution must be submitted to the Office of the Secretary of this Society on or before June 4, 1971. Such amendments may be proposed upon the written petition of fifteen Active, Senior Active, *Resident or Intern members of the Society, or by the Committee on Constitution and By-laws. (* Due to a printing oversight, Resident and Intern members were not included in Article XV, (subsection ii) of the Constitution when it was last printed on October 7, 1970.)

Raymond C. Grandon, M.D.
Secretary

Society foundation plans shared at session

Representatives of more than two dozen state and national health, labor, governmental, insurance, industrial and legislative organizations have met with the Pennsylvania Medical Society to hear about its plans for changes in the financing of health care for Pennsylvanians.

The meeting was called by the medical society's Subcommittee on the Pennsylvania Medical Care Foundation, chaired by Matthew Marshall, Jr., M.D., of Pittsburgh, to explain the concept of the foundation and to answer questions about it.

According to Dr. Marshall, the plan would impose certain controls on physicians who in turn would expect others in the health care field to accept similar regulations.

It was an eye-opener for those who have been casting doctors and their organizations in "bad guy" roles.

The plan would establish cost, quality and quantity controls and reward the prevention of illness. It would establish a statewide medical care foundation involving the public, physicians, hospitals and other medical facilities, the Blue Plans, commercial insurance companies, state and federal government, labor unions, industry and other employers and incorporated medical care groups.

The foundation plan still is in its formative stages. A number of steps must take place before it can come into being. As an example, although the foundation plan is a Pennsylvania Medical Society concept approved by the House of Delegates in 1970, the precise structure is subject to the delegates' approval at this year's meeting. The plan also requires participation of and funding from other sources.

Among a number of services and functions, the foundation would:

- Offer a mechanism for prepayment medical-health insurance plans akin to Kaiser Permanente prepayment plans on the west coast and elsewhere;
- Provide mechanisms to make hospital stays minimal and prevent unnecessary hospital admissions;
- Contract with the federal government to provide the full range of health services to medicare recipients;
- Contract with state government to provide the full range of health and medical care services to medicaid recipients;
- Provide committees that would review health and medical care costs, quality and quantity—an extension and coordination of activities already being carried out by the medical profession in the state.

One of the major pressures for the establishment of such a foundation with medical profession supervision is the proposal of the U.S. Senate Finance Committee for the establishment of Professional Standards Review Organizations (PSRO). A member of the staff of the Senate Finance Committee attended the meeting to explain that the foundation, at least in federally funded health care programs, would have the responsibility and the authority to establish standards affecting not only physicians but hospitals, nursing homes and other health and medical care institutions. Nationally, hospitals are opposed to the plan because it would give medical societies and physicians greater control over hospital medical care standards.

International symposium scheduled to study VD epidemic solutions

Experts from the United States and Europe will meet April 15-16 in St. Louis to consider how to halt the rise of venereal disease which has reached epidemic proportions in many areas of the world.

About 150 private and public health physicians, VD authorities and representatives of medical societies from every state and several European countries are expected for the International Venereal Disease Symposium.

The symposium will be cosponsored by the American Social Health Association (ASHA) and Pfizer Laboratories.

Bruce Webster, M.D., chairman of the National Commission on VD recently established by the U.S. Department of Health, Education and Welfare, will chair the symposium. Dr. Webster also is president of ASHA and clinical professor of medicine, Cornell University Medical College.

"We know that more than two million Americans will contract venereal disease, principally gonorrhea, this year and the real number could be much greater than that," said Dr. Webster.

"The incidence of venereal disease is rising very rapidly, faster than the consumer price index, which is a concept everyone understands in these inflationary times.

"I don't like to be an alarmist, but unless a massive, national effort is made to fight venereal disease, especially among our young people, we could be facing a national tragedy. Many other countries face the same prospect."

Speakers will discuss many aspects of the problem—medical, social, cultural, economic, educational and behavioral. Dr. Webster said the first day of the symposium would be spent "comparing notes" on the situation, and the second day would feature workshops devoted to searching out new approaches to halting the spread of VD.

Dr. Thorstein Guthe, chief medical officer, Venereal Diseases and Treponematoses, World Health Organization, said recently that the sharp increase in VD amounted to an epidemic in many nations.

ASHA estimates there were 2,000,000 cases of gonorrhea and 75,000 new cases of infectious syphilis in the United States during the year ending June 30, 1970. It has found that most cases treated by private physicians are not reported to public health officials.

A recent report to the 47th session of the executive board of the World Health Organization in Geneva said the spread of gonorrhea is very serious, with increases in 1970 of 7 per cent in the United Kingdom, and 15 per cent in Denmark and Canada.

THE WOMAN'S AUXILIARY of the York County Medical Society again this year has taken "positive action" to induce young people to pursue careers in health fields by sponsoring a career day at York Hospital. Over 300 seniors from the county's high schools were introduced to twenty health fields in need of manpower. Several of these careers can be pursued after completion of high school. The career day was the highlight of a program of continuing education over the past several months through which York Hospital and the auxiliary have presented health careers ideas to school guidance counselors. One such field is inhalation therapy, as demonstrated above by Leon Shirk, chief inhalation therapist, to Ion Deckman, of Dover.

State reports cancer deaths down

The Pennsylvania Department of Health reports for the first time in ten years a decrease in the rate of cancer deaths in the state. Cancer, however, remains the second leading cause of death being exceeded only by heart diseases, which account for 41 per cent of total deaths.

Deaths per 100,000	1968	1969
	187.7	187.4

Order of Cancer Mortality - 1969

FEMALES	MALES
breast	lung
colon	colon
uterus	prostate
lung	stomach
ovary	pancreas

Changes Since 1930

	1969
Respiratory (both sexes)	+985.8%
leukemia	+285.0%
pancreas	+220.7%
buccal cavity	decreased
liver	decreased
stomach	decreased
cervix	decreased

Auxiliary sponsors VD training program

An educational program on VD is being offered in Dauphin County. The Woman's Auxiliary of the Dauphin County Medical Society and the state health department's division of public health education sponsored the initial session for ten school districts including administrators, principals, school nurses, and teachers.

Dauphin County currently ranks third in the state in reported incidence of VD. Mrs. John S. Bray, president of the auxiliary, noted that the county project is being conducted to promote community awareness of the serious consequences of venereal disease and to promote local action to curb the problem.

Psychiatrists to meet April 16 at Hershey

The annual meeting of the Pennsylvania Psychiatric Society will be held April 16-18 at the Hershey Hotel in Hershey. The theme of the session is "Encounter Groups, Marathons, and Sensitivity Training." The keynote address is to be given by Charles Seashore, Ph.D., a resident fellow of the National Training Laboratory Institute. On Saturday micro-lab demonstrations will be presented.

Drug symposium at pharmacy college

The Philadelphia College of Pharmacy and Science will conduct a symposium on drug abuse April 21 at the college. The program includes the following topics: (1) reducing drug abuse through education, (2) international illegal drug traffic, (3) marijuana—a pharmacological profile, (4) abuse of hallucinogenic agents, (5) methadone treatment of narcotic addiction, (6) the bridge—a new concept in resocialization, (7) psychological and sociological factors involved in treatment planning for drug abusers.

All pharmacists and others interested in the drug abuse problem are invited to attend. The registration fee, including the cost of luncheon, is $5.00.

State loses 919 G.P.'s in two years

From 1967 to 1969 there was an increase in the total number of physicians in Pennsylvania and the nation, yet there was a decline in the number of physicians taking care of patients. Pennsylvania suffered a whopping 32 per cent of the national decline in patient-care doctors.

Figures released by the American Medical Association show the physician population in Pennsylvania during the two-year period increased by 421, while physicians in patient care showed a net loss of 565.

Although increases were registered in some specialties, general practitioners in the state declined by 919 and physicians in surgical specialties dropped by 193.

The greatest increases came under the categories of "Other Professional Activity" and "Inactive." "Other Professional Activity," which includes teaching, research, and administration, climbed by 511 and "Inactive" showed a gain of 475. Hospital-based physicians increased by 226.

Nationally for the same period the total number of physicians increased by 13,979 while the number of physicians delivering care slipped by 1,765. General practitioners declined by 11,404.

The major national increases, which more than counterbalance the nearly 14,000 new physicians produced during the period, again occurred in the areas of "Other Professional Activity" (8,747) and "Inactive" (6,997).

The jump in the number of inactive physicians has been attributed in part to high practice costs, such as for malpractice insurance, which prevent many older practitioners from taking care of patients on a part-time basis.

1967-1969

Date	Total Non-Federal Physicians	PATIENT CARE						Other Professional Activity	In active
		Total	OFFICE BASED PRACTICE				Hospital Based Practice		
			General Practice	Medical Specialties	Surgical Specialties	Other Specialties			
U.S. AND POSSESSIONS									
December 31, 1967	279,418	249,273	62,757	40,113	56,636	30,573	59,194	17,247	12,898
December 31, 1969	293,397	247,508	51,353	41,818	56,396	34,788	63,153	25,994	19,895
TOTALS	+13,979	−1,765	−11,404	+1,705	−240	+4,215	+3,959	+8,747	+6,997
PENNSYLVANIA									
December 31, 1967	17,163	15,380	4,101	2,206	3,376	1,620	4,077	1,180	603
December 31, 1969	17,584	14,815	3,182	2,272	3,183	1,875	4,303	1,691	1,078
TOTALS	+421	−565	−919	+66	−193	+255	+226	+511	+475

Hahnemann checks cardiac pacemakers by phone

"Heart Station" at Hahnemann Hospital has concluded a test study on sixty-eight people with pacemakers. These patients were checked weekly or monthly by telephone. Ronald S. Penhock, M.D. reported to a meeting of the American College of Cardiology at Washington, D.C., that no cases of unpredicted failure occurred during the test, although eight failures were experienced.

Ninety per cent of all failures are caused by battery failure. When the patient calls in, a technician monitors the electronic sensors. The patient needs a small kit which contains the leads to send the signal across telephone wires. As long as he can get to a telephone, he can be checked on a regular schedule. New pacemakers are checked once a week for eight weeks, then once a month up to eighteen months, and for the duration of their effective lives a weekly check is made.

Pacemaker Evaluation Systems, Inc., 1705 Walnut St. in Philadelphia has a telephone with a data coupler, an amplifier for the telephone, a digital read-out counter, and patient data sheets.

Results have shown that the patient is saved worry about a sudden pacemaker failure and the frequency of replacement can be extended from eighteen to twenty-four months, saving both trauma and money.

PMS FIFTY-YEAR AWARDS were made to three Luzerne County physicians recently at a banquet which featured the installation of the new officers of the Luzerne County Medical Society. Shown above, left to right, are PMS Board of Trustees Chairman Park M. Horton, M.D., who presented the awards; Mrs. Horton; Lewis S. Reese, M.D., an awardee; Mrs. Reese; Mrs. Marsden; W.C. Marsden, M.D., and George W. Taggart, M.D., both of whom received the awards. George B. Davis, M.D., of Kingston, was installed as president of the society.

State to aid municipalities planning solid waste management

Pennsylvania's Solid Waste Management Advisory Committee wants the state to continue its policy of reimbursing municipalities half of what it costs them to prepare official solid waste management plans.

At a recent meeting the advisory committee went on record as endorsing a request by the Department of Environmental Resources for sufficient funds to fulfill the Commonwealth's commitments to municipalities whose applications for solid waste planning grants have been approved. Pennsylvania's Solid Waste Management Act authorizes the department to assist counties, municipalities and authorities by administering grants to pay up to 50 per cent of the costs of preparing official plans for solid waste management.

Precedent for reimbursing municipalities at the maximum rate under the act was set in February 1968 when the advisory committee adopted the "Conditions and Procedures of Grant for Solid Waste Management Planning." Subsequently, the committee recommended that each agency receive half of its reimbursement allocation at the onset of planning and the other half after the completed plan has been approved and adopted.

Each municipality with a population density of 300 or more persons per square mile must prepare, approve and submit a plan for solid waste management systems serving areas within its jurisdiction. Through resolutions, municipalities may join together with neighboring communities for planning or may decide to plan either on the county-wide or regional level as recommended both by the Department and the Advisory Committee.

Medical assistants meet in Pittsburgh

The fourteenth annual convention of the Pennsylvania Society of the American Association of Medical Assistants is meeting May 13-16 at Chatham Center in Pittsburgh. Pittsburgh Mayor Peter Flaherty has proclaimed May 14 as Medical Assistants' Day. Governor Milton J. Shapp has designated the entire week Medical Assistants' Week. Because of growing demand for qualified assistants, the week will be dedicated to launching an extensive career recruiting campaign, the society announced.

Doctors can help support this concentrated effort, the society says, by encouraging their secretaries, technicians, and other assistants to attend. There will be a preconvention tour of the "new Pittsburgh" on Thursday, May 13. Convention seminars will be presided over by clinicians and instructors in the medical sciences who are assisting in the presentation of "Horizons Unlimited," the theme of the convention.

PMS co-sponsors forum

A number of agencies including the Pennsylvania Medical Society are sponsors of the First Pennsylvania Comprehensive Health Care Forum to be held April 6-7 at the Penn Harris Motor Inn conference center in Camp Hill.

The purpose of the forum is to study national and state proposals for the delivery of health care to the citizenry of Pennsylvania and to bring before and exchange with health professionals, industry, civic and consumer leaders the varied proposals being introduced which could affect Pennsylvania's health care delivery system.

Review of patient needs required by law

New federal regulations implementing a Social Security Act amendment have been announced by John D. Twiname, administrator of the Social and Rehabilitation Service. These new regulations will require that the health needs of medicaid patients in skilled nursing homes and mental institutions must be reviewed and evaluated at least once a year.

State medicaid agencies will provide a medical review and treatment plan for each patient, together with a rehabilitation plan where applicable.

Whereas former regulations have dealt with the proper licensing and the control of overcharges and excessive costs, the new medical review, accompanied by short notice inspection requirements, will change the focus to meeting the needs of the individual.

Objectives are to determine whether each patient is in an institution appropriate to his condition, with emphasis on the kind and quality of care being given.

AMA environmental meeting in New York

New York's Governor Nelson A. Rockefeller will give the keynote address at the 1971 annual Congress on Environmental Health of the American Medical Association April 26-27 at the Essex House in New York City.

Theme of the 1971 Congress will be "Solid Waste Management—Today and Tomorrow."

Luncheon speakers for each of the two days of the congress will be officials of the two top federal agencies dealing with environmental pollution. Gordon J. MacDonald, Ph.D., member of the Council on Environmental Quality, Washington, D.C., will give the luncheon address April 26. William D. Ruckelshaus, administrator of the Environmental Protection Agency, Washington, D.C., will be the luncheon speaker Tuesday, April 27.

Welcoming addresses at the opening session will be given by Wesley W. Hall, M.D., Reno, Nev., president-elect of AMA, and George Himler, M.D., president of the Medical Society of the State of New York.

The congress will be held under the auspices of the Council on Environmental Health of the AMA. John S. Chapman, M.D., of Dallas, is council chairman. Dr. Chapman is assistant dean of the University of Texas Southwestern Medical School at Dallas and also is editor of the Archives of Environmental Health, the AMA's professional journal dealing with this aspect of medicine.

Malpractice plan tested

The Hartford Insurance Group has initiated an experimental malpractice insurance program in Los Angeles and six adjacent counties in California called "Comprehensive Professional Liability Insurance Plan for the Southern California Physicians Council."

The "peer review" of doctor's performance is considered a vital step toward solving the mounting crisis in professional liability coverage by the Hartford Group. Fellow physicians would act on fee complaints, evaluate the diagnostic, medical and surgical procedures used, judge on ethical conduct, and take disciplinary action. In the last analysis the insurance industry must have the support and cooperation of the medical fraternity in order to solve the problems of malpractice insurance, the Hartford Group feels.

The company feels that the inability of insurance companies to write malpractice coverage at a profit can be attributed to deteriorating doctor-patient relationships, extraordinary jury awards for commonplace injuries, contingency-fee practices in the legal system, mounting public sophistication in medicine and unhappiness over medical fees.

M.D. - D.O. diabetes seminar at Hershey Medical Center April 17

A scientific seminar on diabetes for doctors of medicine and osteopathy will be held at the Hershey Medical Center April 17, 1971, starting at 9 a.m. and lasting the full day.

Introductions will be made by Raymond C. Grandon, M.D., Harrisburg, and a welcoming address will be given by George T. Harrell, Jr., M.D., dean of Pennsylvania State University College of Medicine at Hershey.

A film, "Diabetes: Puzzling but Promising," will be shown, with Charles W. Worrell, D.O., Harrisburg, acting as moderator for the discussion of the film. For the remainder of the morning session, Ralph Tomei, D.O., Philadelphia, will act as moderator. Subjects and speakers will include: "Current Concepts of the Etiology of Daibetes," Joseph J. Rupp, M.D., Philadelphia; "The Pregnant Diabetic," Harvey Knowles, M.D., Cincinnati, O.; and "Ketotic and Non-Ketotic Acidosis and Coma," Alexander Marble, M.D., Cambridge, Mass.

All morning speakers will participate in the afternoon session, "Therapy of Diabetes." Charles Bordin, M.D., Philadelphia, will moderate the panel discussions which will have three subjects. The first is "Oral Agents and the University Group Diabetic Program (UGDP) Controversy." Other subjects are "Diet" and "Present Day Use of Insulin and Control of Coma."

Last year's initial M.D.-D.O. seminar was on hypertension and vascular diseases and featured experts in that field.

Health council meeting studies role of patient

The Pennsylvania Health Council will hold its twenty-first annual meeting April 19-20, 1971, at the Hershey Motor Lodge at Hershey. Registration for the two-day meeting on the theme "The Individual—Keystone to Health Maintenance," will begin at 8 a.m.

The morning will be devoted to a business session. George T. Harrell, Jr., M.D., dean of the Pennsylvania State University College of Medicine, Hershey, will serve as moderator of the afternoon sessions on predictive medicine, family health maintenance and developments in bio-technology.

Other sessions will discuss new directions in health maintenance, new directions for public and voluntary health agencies and preventive health maintenance.

A trio of Pennsylvania physicians: **Gilbert M. Rothrock, M.D.,** York; **Edward G. Dailey, M.D.,** Harrisburg; and **William H. Druckemiller, M.D.,** Erie, accompanied by their wives, attended the annual winter meeting of the American Medical Tennis Association (AMTA) held at the T Bar M Tennis Ranch, New Braunfels, Tex. The meeting included daily scientific meetings and tennis competition. Dr. Rothrock won the open singles, defeating Robert Ouwendijk, M.D., Ventura, Cal., in the finals, 6-2, 6-4. In the open doubles, Dr. Rothrock and Dr. Dailey teamed to win the championship, defeating a doubles team from Oklahoma City.

Physicians wishing to have further information concerning AMTA may contact William Drake, Executive Secretary, Box 183, Alton, Ill. 62002.

New Kensington Alcoa wins safety award

The Aluminum Company of America's New Kensington Operations received the Pennsylvania Medical Society's 1970 Occupational Health Award March 10 at the New Kensington Area Chamber of Commerce annual meeting.

C. L. Kamperman, M.D., Alcoa's New Kensington medical director, accepted the statewide honor from Joseph J. Schwerha, M.D., Finleyville, chairman of the PMS Commission on Environmental Health.

"The comprehensive medical program at Alcoa's New Kensington plant, research laboratories and technical center was an outstanding one, and a model that other companies should seek to emulate," Dr. Schwerha said in commenting on the company's program.

The occupational health awards are given annually to motivate companies in the state to establish or improve medical services for their employees. Alcoa's New Kensington Operations was selected in the large company category. Winner of the small category award was the National Lead Company, Philadelphia Branch.

The Alcoa program was nominated for the state award by the Westmoreland County Medical Society, represented at last night's meeting by two Greensburg physicians, Alan W. Shriver, M.D., chairman of the society's Industrial Health Committee, and Donald M. Blatchley, M.D., a committee member.

$42 billion spent on health in 1969

Americans spent a record $42 billion on health care in 1969, reports the new edition of the *Source Book of Health Insurance Data.*

Per capita expenditures for medical care rose to $208 in 1969—a 98 per cent increase over the $105 of 1959.

The twelfth annual edition of the publication of the Health Insurance Institute contains (1) latest information on types of insuring organizations in U.S., (2) amounts of premiums received and benefits paid, and (3) data on costs of medical care and frequency of illness.

Coverage figures are given for the five major types of health insurance; hospital expense insurance, surgical expense insurance, regular medical expense insurance, major medical expense, and short term disability insurance. A breakdown is furnished for policyholders under and over the age of sixty-five.

APHA backs Kennedy bill

The American Public Health Association (APHA) has described S.B.3 and H.R.22, the Congressional bills proposing a national health insurance, as "meeting the needs of the nation," and has pledged full support of the proposals. The bills were introduced in the Senate and House of Representatives by Sen. Edward M. Kennedy (D-Mass.) and Rep. Martha W. Griffiths (D-Mich.), with a number of cosponsors.

Wainwright Tumor Clinic meets May 11

The annual meeting of the Wainwright Tumor Clinic Association will be held May 11, 1971, at the Harrisburg Polyclinic Hospital, with William Tyler Douglass, Jr., M.D. presiding. Drs. Charles A. Waltman, Easton; Richard C. Putnam, Philadelphia; M. Peter Scibetta, Erie; and David W. Clare, Pittsburgh; will present case reports under the title "From the Four Corners of the State—The Most Challenging Cases of the Year."

Four specialists will participate as discussants: Johathan E. Rhoads, M.D., chairman of the department of surgery, Hospital of the University of Pennsylvania; John A. Finkbeiner, M.D., Memorial Hospital of New York City; Frank Batley, M.D., chairman of the department of radiation therapy at Ohio State University Medical School; and William Shelley, M.D., director of laboratories of Memorial Hospital at Charlotte, North Carolina.

A unique, high speed ambulance unit designed exclusively for use with heart victims, is presently saving 150 lives yearly, according to Dr. J. Frank Patridge, chief cardiologist, Royal Victoria Hospital, Belfast, Ireland.

Nicknamed "The Flying Column," the ambulance, packed with sophisticated portable heart-testing equipment and a team of four, including two resident physicians, a staff nurse and an intern, can race from the hospital to the victim's side in an average of twelve minutes time. The ambulance uses a special telephone number permitting doctors, patients, and incoming calls to bypass the hospital switchboard.

Once the emergency alarm is sounded, the team rushes into action, en route to the victim.

Upon reaching the patient, the ECG is quickly attached to his body, with the team receiving heart-rhythm readings within two to three minutes. The electrocardiogram changes are also noted and primary aid begins.

'Dial Access' program initiated by VA

The VA's 5,000-plus physicians and an equal number of residents, interns, and consulting physicians will have access to a new service for the exchange of medical information called "Dial Access Medical Lectures." This represents an addition to the two million dollars a year program including motion pictures, closed circuit television, video tape recorders and replay facilities, open broadcast videotapes, cartridged film, and telephone-radio conference facilities currently being widely used.

Doctors at most of VA's 166 hospitals can now have instant access to short lectures on specialized medical subjects prepared by specialists. A catalog of the lectures and a federal telecommunications service telephone are all that is necessary for receiving medical information on a variety of subjects ranging from "Blood and Lymphatics" to "Suicidal Threat."

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When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-107/4/71/U.S. PATENT NO. 3,001,910

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Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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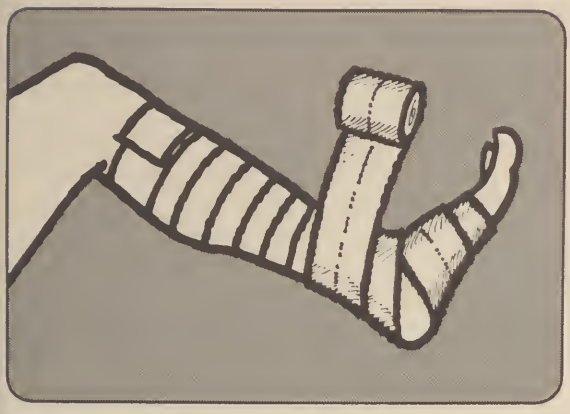

A practical, ambulatory treatment for leg ulceration

The Flexible Cast: The PRIMER medicated bandage, in conjunction with the FLEXOPLAST elastic adhesive bandage, comprise the cast.

This is a more comfortable and faster method of healing than Unna's Boot. Frequent changing of the dressing is eliminated. The newly forming granulation and epithelium are left undisturbed. It is the modern form of treatment.

EDWARD TAYLOR Ltd.
A Division of Glenwood Laboratories Inc.
Tenafly, New Jersey 07670

Gentlemen:

Please send me

☐ literature

☐ samples of PRIMER medicated bandage and FLEXOPLAST elastic adhesive bandage.

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THIS SPACE CONTRIBUTED BY THE PUBLISHER

the quality of survival

With the steady improvement in the therapy of cancer, and consequent increase in the number of 5-year survivals, our programs reflect increasing concern with the future of the cancer patient—with the *quality* of his survival.

High priority is being given to the rehabilitation of cancer patients—those having had mastectomies, colostomies, laryngectomies, amputations, and other drastic treatments for cancer.

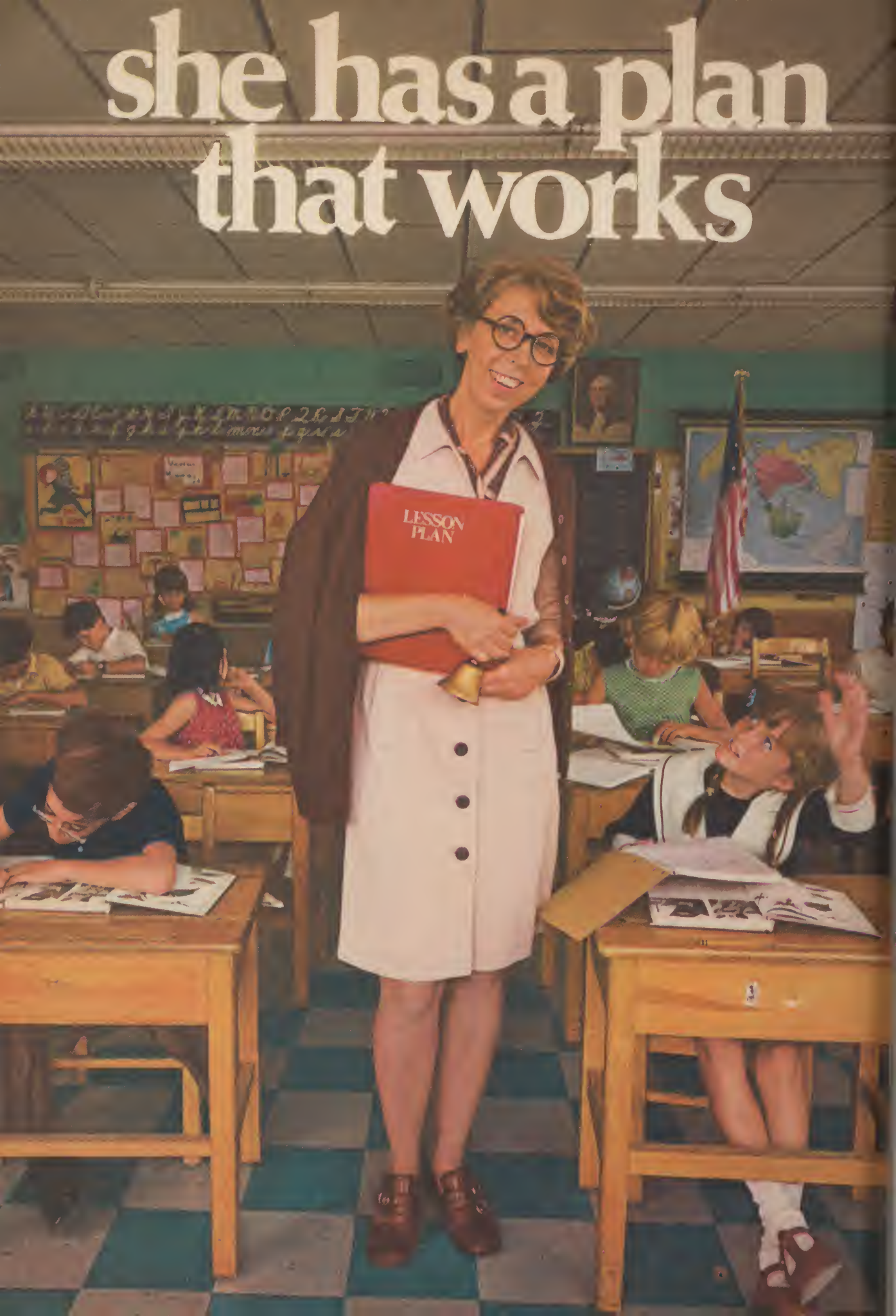
Our "Reach to Recovery" program is a dramatic example. This program helps the physician meet many special needs of the postmastectomy patient on the road to total recovery. Patients receive psychological reassurance and practical help from women who have had the same surgery.

The laryngectomee also receives the benefit of our rehabilitation program.

Supported by the Society, the International Association of Laryngectomees, through its local IAL clubs, provides such services as individual and group speech therapy, psychological counseling, visits to new patients, safety training, public education and social activities.

Our rehabilitation programs not only give heart and help to patients but provide the physician with vital aids necessary to improve the *quality* of survival.

American Cancer Society


she has a plan
that works
LESSON
PLAN

She has a plan that works.

She has one plan for the class. And they really respond.

She has another plan just for herself. A medication plan for her hypertension. And she's also responding beautifully.

More than just another antihypertensive, Ser-Ap-Es can be a whole medication plan for living with hypertension.

Does it get good marks for comfort?

Excellent. Because Ser-Ap-Es controls blood pressure effectively, dosage of each component is lower than if prescribed alone, usually minimizing side effects. However, side effects may occur (see prescribing information).

Designed with the kidney in mind?

Hydralazine maintains or increases renal blood flow.

And the brain too?

Hydralazine also relaxes cerebral vascular tone. And reserpine has beneficial calming action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

Practical on a teacher's salary?

Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits…

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

C I B A

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

a plan for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

INDICATIONS: All cases of hypertension except the mildest and the most severe.

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

Hydralazine: Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Reserpine: The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydralazine: Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

Hydralazine: Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Reserpine: Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

Hydralazine: Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE: One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

SUPPLIED: *Tablets* (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Summit, New Jersey

2/4624

she has a plan that works for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

CIBA

m.d.'s in the news

In a joint resolution, the board of directors and medical staff of Rochester General Hospital have honored **Thomas W. McCreary, M.D.,** by designating the hospital laboratory as the Thomas W. McCreary Pathological Laboratory. Dr. McCreary founded the laboratory in 1929 and headed it since that time until his retirement December 31, 1970. Although retired, he has continued to work at the laboratory several days a week, and will serve in the future as a laboratory consultant.

Five Luzerne County doctors have been honored at a dinner meeting of the Luzerne County Medical Society with certificates in recognition of fifty years of service in the profession. They are **Vincent Gallizzi, M.D.,** Pittston; **Frank Conlon, M.D.,** Pittston; **L. S. Reese, M.D.,** Kingston; **W. C. Harsden, M.D.,** Wilkes-Barre; and **George Taggert, M.D.,** Hazleton.

Jack Edeiken, M.D., has been appointed chairman of the department of radiology at the Jefferson Medical College and Thomas Jefferson University Hospital. Dr. Edeiken, who studied under **Eugene P. Pendergrass, M.D.,** at the University of Pennsylvania Medical School, is currently revising his book, *The Roentgen Diagnosis of Diseases of Bone.*

DR. EDEIKEN DR. DEGENNARO

Brent S. Follweiler, M.D., has been appointed to head the department of anesthesiology at Paoli Memorial Hospital. **Edward R. Deverson, M.D.,** is the new director for John J. Kane Hospital, Pittsburgh. He will also serve as executive director of the county institution district, being a senior physician in geriatric medicine. Other new hospital appointments are those of **Thomas F. Fletcher, M.D.,** associate director for medical affairs at Harrisburg Hospital, and **Patrick J. DeGennaro, M.D.,** Danville, associate in the department of radiology at Geisinger Medical Center. Dr. Fletcher will also serve as a medical staff liaison with the Milton S. Hershey Medical Center, coordinating the curriculum for the hospital, which serves as a clinical teaching facility for third and fourth year students. Dr. DeGennaro has recently returned after serving in the U.S. Army Hospital in Japan.

New president of the Central Pennsylvania Academy of Medicine is **R. Edward Steele, M.D.,** succeeding **Thomas E. Bowman, Jr., M.D.**

The Bucks County Psychiatric Center has moved to a new location in Chalfont. The new facilities include five professional offices, two business offices and a waiting room. **Thomas Woodman, M.D.,** of Point Pleasant, is now medical director.

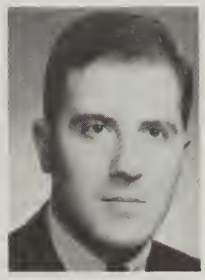
A five-year National Institutes of Health Research Development award and grant has been received by **Marcus M. Reidenberg, M.D.,** of Temple University School of Medicine. His work will investigate the metabolism of drugs in patients with kidney disease.

Sol Sherry, M.D., chairman of the board of medicine at Temple University School of Medicine, was awarded the Franz M. Groedel Medal by the American College of Cardiology. Dr. Sherry, together with a group of colleagues, demonstrated clinically late last year that a chemical extracted from urine, called urokinase, can effectively dissolve blood clots in the lungs.

Arthur H. Keeney, M.D., ophthalmologist-in-chief to Philadelphia's Wills Eye Hospital and chairman of the department of ophthalmology of Temple University School of Medicine, has been named chairman of the American National Standards Institute Z-80 committee on ophthalmic lenses.

The Beaver County Medical Association has honored **J. Willard Smith, M.D.,** for thirty-one years of service as secretary-treasurer. A $500 grant, the J. Willard Smith, M.D. Scholarship, will be awarded to a student majoring in nursing at Beaver County Community College.

Joseph A. Cipcic, M.D., clinical instructor at the University of Pittsburgh School of Medicine and Department of Speech, is serving on the faculty of a workshop on maxillofacial fractures co-sponsored by the American Academy of Facial Plastic and Reconstructive Surgery, Inc., and the University of Cincinnati Medical Center. **Joel Porter, M.D.,** will serve as an instructor of ophthalmology for the eye clinic at Temple University Hospital. He will be responsible for coordinating the out-patient department and training residents as well as teaching medical students.



DR. PORTER

DR. SHAW

William W. Brubaker, M.D., is the newly appointed corporate medical director for Hershey Foods Corporation. Another industrial appointment is that of **Daniel L. Shaw, Jr., M.D.,** to vice-president of medical affairs for Wyeth Laboratories. Dr. Shaw will be responsible for advising the company on matters of a medical nature and acting as liaison on international medical projects.

The appointment of **Gerald H. Escovitz, M.D.,** as chief of Regional Medical Program activities and coordinator of community programs at the Medical College of Pennsylvania has been announced. The College of Medicine at the Milton S. Hershey Medical Center of Pennsylvania State University announced the appointment of **Richard P. Sacks, M.D.,** as assistant professor of radiology. He will serve as a diagnostic radiologist, teach medical students, interns and residents, and continue his research.

Archibald Laird, M.D., retired Brigadier General in the Pennsylvania Army National Guard, and former opthalmologist in Wellsboro, has written a book entitled, *Monuments Marking the Graves of the Presidents.*

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the night shift of depression... insomnia

Depression is a 24-hour-a-day problem. And insomnia is often its nocturnal expression. In fact, insomnia may be a key symptom in establishing the diagnosis of depression.

ELAVIL HCl (Amitriptyline HCl, MSD) may prove quite helpful when you have arrived at such a diagnosis. Unlike psychic energizers or agents that merely elevate mood, ELAVIL HCl embodies a mild antianxiety action which manifests itself even before the fundamental antidepressant activity of the drug becomes evident. Daytime drowsiness occurs in some patients, usually within the first few days of therapy.

NOTE: Not recommended during the acute recovery phase following myocardial infarction. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

Contraindications: Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

Precautions: When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be exaggerated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as perphenazine, concurrently.

When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, and 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives.

For more detailed information, consult your MSD representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

when the diagnosis is depression

ELAVIL® HCl
(AMITRIPTYLINE HCl | MSD)

MSD MERCK SHARP & DOHME

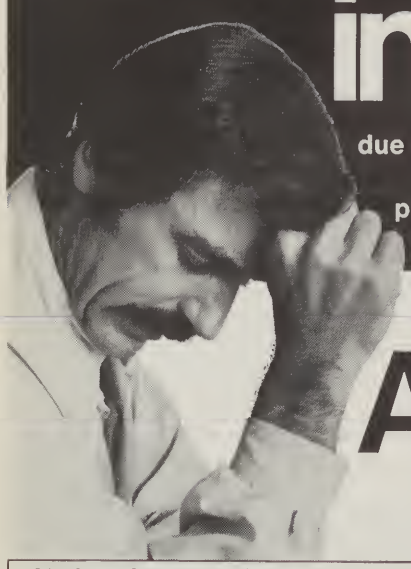
The treatment of

impotence

due to androgenic deficiency in the American male. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients—Double Blind Study) T. Jakobovits Fertility and Sterility, January 1970 Official Journal of the American Fertility Society



Android®

(thyroid-androgen) tablets

Double-Blind Study and Type of Patient:
100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

REFER TO PDR

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangalista, t.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25), Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

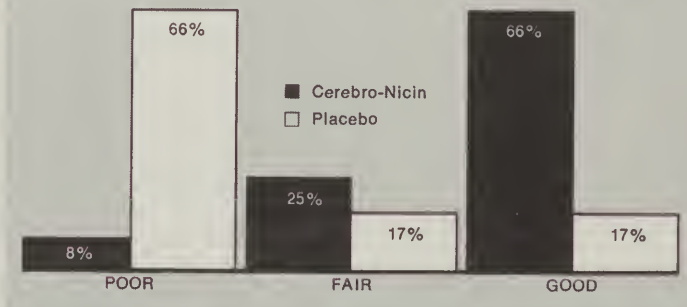
Write for literature and samples: BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West 6th Street, Los Angeles, California 90057

For the treatment of the aging patient

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir 8 oz. bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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2500 W. 6th St., Los Angeles, Calif. 90057
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PENNSYLVANIA MEDICINE feature

The health care of the poor

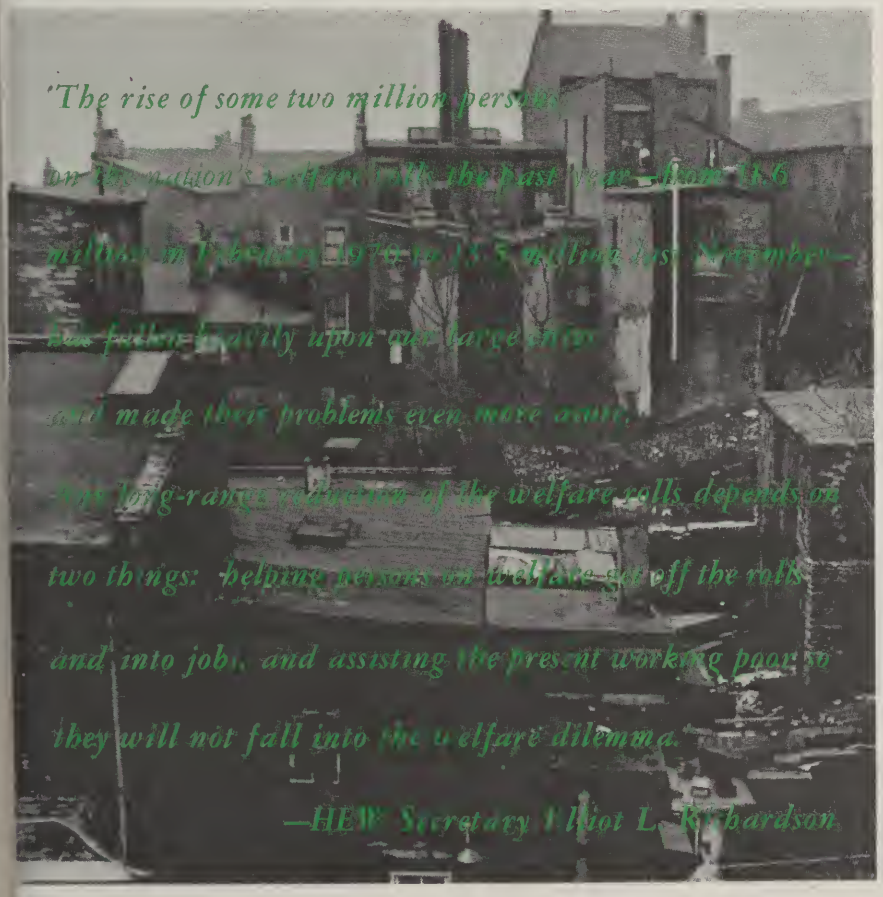
How Temple meets a need

ARTHUR D. NELSON, M.D. and JAMES N. SNIPE, M.P.A.

Philadelphia

ALTHOUGH questions are being raised about all elements of our health care delivery system, there is little disagreement that the problems of access to the system and equity in enjoying its benefits are at their worst in the urban core setting. The Comprehensive Health Services Program of Temple University was designed to attack these problems by bringing the socio-economically disadvantaged urban patient back into the mainstream of medicine. Here are some preliminary observations and comments upon the program, together with a few throughts for the future.

A measure of the difficulty of delivering health care in the inner city is the number of physicians who, having found it impossible, are now practicing in the affluent suburbs. If traditional modes of delivery have failed, for whatever reason, then surely a new approach is warranted. Temple University's Health Sciences Center, in cooperation with the City of Philadelphia, the Office of Economic Opportunity (OEO), HEW, and others, has been working to develop a system of comprehensive patient and family-centered care which includes neighborhood health centers tied into existing health delivery resources. The program began with the assumption that from an established base more than one center could be operated, with attendant economy of scale. One objective has always been to find ways in which to make the new delivery system self-sustaining and independent of grant support.



Early discussions with community groups led us to understand that access to primary care was a major consideration. Therefore, we placed ambulatory centers right in the areas to be served.

The Comprehensive Group Health Services (CGHS) Center was established in a former loft building already housing a Children and Youth Program sponsored by St. Christopher's Hospital for Children. This center offers medical, dental, mental health and other services to economically-disadvantaged, geographically-defined residents of the community. The availability under one roof of laboratory, x-ray, and optometric-opthalmologic services, in addition to the usual professional services, makes care more convenient than in the fragmented clinic settings which have been inadequate to the needs of the community. Within two years after this center opened, 104 per cent of the designed patient load had enrolled.

An attempt has been made to set up comprehensive services, also, at the West Nicetown-Tioga Center, where we have experienced most of the difficulties known to man. First, we ran into deep-seated community distrust,

and even animosity, toward the sponsoring institution. Next, preparation of architectural changes to the only large building in the area, and legal difficulties in acquiring the property, held us up. Then, when we were ready to go to bid, OEO withdrew its grant authorization for renovation and required that the institution secure a loan and apply for an FHA guarantee as a group practice and diagnostic and treatment center to cover acquisition and renovation costs. As an interim approach we decided to deliver services in trailers which themselves had to be renovated. Then began the extended negotiations needed to bring lawyers from the City of Philadelphia and its Anti-poverty Commission; the mortgagor, Penn Mutual; OEO; the General State Authority; FHA; and Temple University all together in a common agreement. Lawyers are constitutionally disposed to argue. How so many finally managed to agree, we'll never know. Renovation is now more than 90 per cent complete. More than three years after funding, we are beginning to provide some services in the permanent facility. There is an important lesson here. It is easier to conceptualize than to implement. No magic switch exists to turn off all our problems, or turn on solutions.

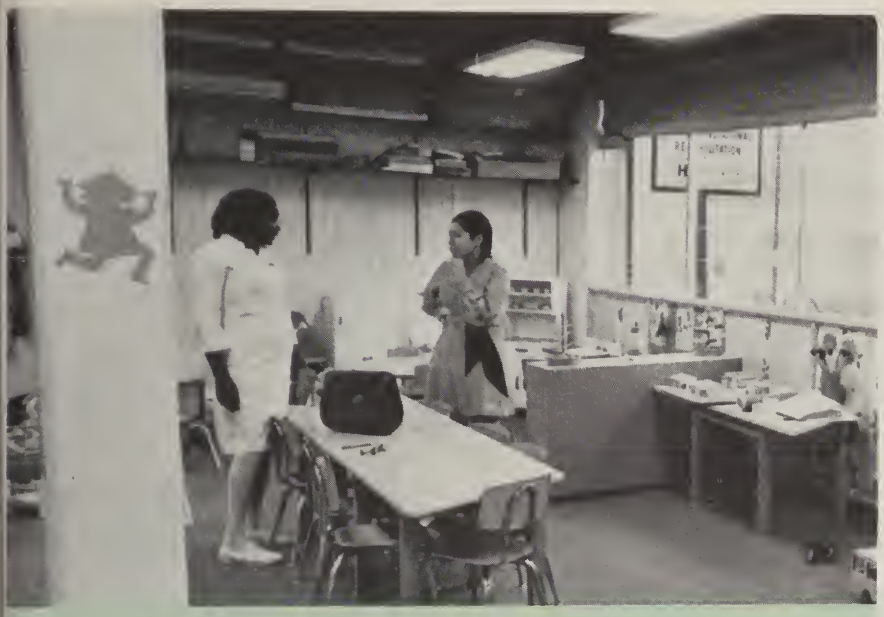
PROGRAM OPERATIONS

Despite our difficulties, the project has enrolled over 18,000 individuals. We not only give service, but use our data system to keep track of what we do. This has given us some insights into the real-world medicine problems our patients face. We have learned that, in addition to acute upper respiratory infections, diseases or disorders most frequently encountered in our area are hypertension, cardiovascular and pulmonary diseases, diabetes, obesity, and neuroses.

Our experience reflects the validity of Dr. John Fry's old dictum, "Common diseases occur frequently. Rare diseases are seldom seen." The implications for undergraduate medical education are obvious: greater emphasis on the commonplace might result in better care for many more people. It would seem the Carnegie Commission is absolutely right in emphasizing the needs for health delivery models in medical education.

We find that allied health professionals and ancillary health workers can provide essential supportive activities following very basic orientation and training. However, the development of well-integrated multidis-

POVERTY EXISTS IN PHILADELPHIA. It is not a hidden commodity. Being poor in material wealth and poor in health go hand in hand, statistics indicate. The higher the number of poverty indicators, the fewer live births, the shorter the lifespan, the higher the incidence of disease, especially controllable diseases such as gonorrhea and syphilis. The photo above shows CGHS staff members offering counsel as to how one can survive in the street depicted below, Germantown Ave. near the CGHS Center.



THE CGHS child development play area, shown above, is in stark contrast with the places children play in the area served by this center. Shown in the photo are Margaret Saunders, family health worker, and Gloria Williams, child care worker. Below is the pediatric waiting area, equipped with items to occupy waiting patients. The windows look out on the neighborhood served by the CGHS Center.

ciplinary teams has not been easy. We constantly observe the staff caucusing by discipline when they should be conferring as a team. Only on an interdisciplinary basis can we provide truly comprehensive care to our patients. If students in all the health professions were taught together, later they might function as a team, rather than as rugged individualists.

Our financial data system enables us to break down cost by cost centers. We also collect demographic characteristics of the population we serve. Our experience with medicaid and medicare populations should be useful in analyzing the need for and impact of national health or national major medical insurance plans.

You will note that we have not quoted unit costs. In any start-up period they are bound to be high. Moreover, there are no costs with which to compare them. OEO programs focus more broadly than on health care alone. For example, employment of indigenous workers is stressed. Community employees bring a new dimension to the effort, but there is an added cost. Their training is also expensive. Data collection, reporting, and evaluation activities are more intensive than in most private practices, and cost more. The FHA mortgage with fast amortization contributes significantly to the cost, and finally, the variety and intensity of services, including social services offered, have no parallel in private health care plans.

Our hope is to expand the geographical area served by our project and thereby increase the number of patients served. Experience to data would lead us to believe that this could be done with little or no expansion of facilities or staff. We believe unit costs will come down. Economy of scale could result and numbers of patients adequate to an actuarially-sound health maintenance organization (HMO) could be achieved.

As matters now stand, comprehensive health care programs such as ours are not and cannot become self-sufficient in low-income areas. We hope the HMO concept will improve that situation, but we'll have to see the law before we can be reassured.

Despite our continuing concern for comprehensive care, we find our patients tend to come in when they are sick. They stay home when they feel well. With few exceptions, *under*-utilization, not over-utilization, has been the problem. As they have told us repeatedly, the disadvantaged are so concerned about jobs, housing, adequate food and clothing, and education for their children that health care is not their highest priority. What is very clear is that any attack on poverty and its consequences must be many-pronged and comprehensive. Our nation cannot be content to worry about health care alone.

COMMUNITY INVOLVEMENT

Community participation has been a mixed blessing to date. Truly, their inputs have been invaluable in under-

standing the needs and priorities of our patients. However, we have had an ongoing difference of opinion as to where policy ends and administration begins. It has been difficult to delegate authority and remain responsible for the consequences of all acts. It is understandable that the disadvantaged, once they get their hands on an arm of the establishment, give it a twist in an effort to effect instantaneous solutions for all the problems of the ghetto. It is unfortunate that they are sometimes willing to go to extreme ends in order to test their authority. We don't have answers to this dilemma, but we are inclined to believe that a health plan corporation, public authority, or public utility model with commensurate authority and responsibility, and with adequate representation from consumers who utilize the services, will more closely answer the need for a governing body.

FUTURE OBJECTIVES

A sense of urgency to solve the so-called "health care crisis" pervades our nation. In the presence of so many imponderables, it seems only logcal to seek answers through collaborative research. This we are doing under contract with the National Center for Health Services Research and Development. In addition, the trustees of the American Medical Association and Temple University have contracted to do research together. We plan to analyze cost variables through use of a mathematical model. We have developed figures which will enable us to project budgets under any circumstances of changing support. We are trying to prepare ourselves to provide factual information when those who set policy ask for cost-benefit analyses of alternative solutions to the problems we face. Until better solutions are found, the landmark accomplishments of the early OEO programs can serve as models for others to follow. Until all Americans can gain equity of access to health care services, we must continue the struggle to expand and improve our health care delivery system.

Dr. Nelson, left, associate vice-president of Temple University Health Sciences Center, presently is engaged in work for the National Center for Health Services Research and Development "Experimental Health Services Planning and Delivery Systems Program." This is a project of the Health Services and Mental Health Administration of the Department of Health, Education, and Welfare. Mr. Snipe has become director of the Temple University Comprehensive Neighborhood Health Services Program. This presentation was made by Dr. Nelson to the 1970 Medical Services Conference in November 1970.

Supported in part by Contract 110-HSRD-146(1) National Center for Health Services Research and Development.

COMPREHENSIVE health services call for a completely equipped one-stop facility. Shown above is the center's x-ray department. Below, Paul L. Jackson, D.D.S., and Dental Hygienist Lola Dillard treat a patient. Services offered in the neighborhood center also include ophthalmology.

The hospital library

JOSEPH T. FREEMAN, M.D., F.A.C.P.
Philadelphia

A chapter in a biography of Charles Willson Peale opens with the observation that: "A man may be characterized by his library, better, at times, than by any other evidence." Even the libraries that a man visits may be expressive of some of his traits. To add to the point. libraries of a nation can reflect national characteristics. For too long, libraries have received the last budget allocation, first financial cut, and lowest priority for special space, particularly in hospitals. Changes must be introduced. The problem now is to cope with the publication of more than one million articles published annually in fifty thousand journals estimated to be "enough scientific material each day to fill seven complete sets of the Encyclopedia Britannica."

In October, 1965, the President of the United States signed the Medical Library Assistance Act "to provide for a program of grants to assist in meeting the need for adequate medical library services and facilities." This was none too soon, foresighted as it was, because the fund of scientific information has been doubling each decade. Individuals no less than libraries are unable to cope with the deluge of data by which information rapidly is translated into practical knowledge.

Although planning for medical libraries never ceases, and awareness of urgent needs has been the librarian's daily portion, progress was slow until the watershed year of 1966. Until then, the average librarian had to run as fast as his shelfbound muscles would permit just to stay in the same place without losing ground. When Congress created the Medical Literature Retrieval and Appraisal System (MEDLARS) and started its machinery July 1, 1966, the effect was immediate. This sophisticated form of documentation slowed traditional deficiencies in publication communications. The new Act promised to "furnish space and facilities for dealing with the massive body of published information "...and also..." advance the processing, storage and retrieval of material vitally needed by health professionals."

THE LIBRARY at Philadelphia General Hospital.

A 1965 study of 79 medical schools found that an average of 32,000 square feet of library space was needed for a total of 2.5 million square feet for all of the nation's medical school libraries. Deficiencies in publications amounted to 1.3 million volumes or an average of 18,000 periodicals and books per school. With the appropriation of federal money, someone's ideas, someone's minority of one became national policy in library programs and structures. The time was gone when the hospital library could be taken for granted; it had acquired the means of exerting a force proportional to its importance in the distribution of scientific information. A guarantee for continuing medical education never had a better friend than the new library Act. But here are questions:

Is the hospital library obsolete? If it is, what can be the alternatives? Can obsoletism be averted by adequate measures?

Can the hospital library of the future serve more complex functions without undergoing major changes?

Will stacks of journals give way to microfilm, and shelves of books to the microfiche cards of a film reader with a photocopy printer attachment?

Will books continue to be produced in the usual way or will they be supplanted by master copies (aside from standard texts and reference works) kept in national or regional library resource centers and made available by a variety of duplicating processes?

Will bibliographies continue to be sought in horse-and-buggy fashion or will this system be replaced in part or in whole by automatic scanning and recalling equipment for as far back as the computer has been programmed?

Will the card catalogue file which is the hub of the library be replaced by devices geared to immediate responses?

Will there be the development of even greater centers of catalogued information of library resources, which can be questioned electronically from any library in the system?

Is there a need for a "Federal Reserve System of Library Resources" in scientific communications?

If some or all of these things come to pass, and probably

the questions are short of the mark, what then will become of the medical librarian?

Congressional policy under the act had seven headings. Each item requires comment for the hospital library, past, present, and future.

Construction of new facilities

The medical school library in the United States has an average of 100,000 volumes and subscribes to more than 1,000 journals. Many institutions are short of these figures

THE LIBRARY is a vital tool in the continuing education of all in the medical profession and its allied fields.

and many surpass them. Space has become a problem and must be evaluated in terms of use. Libraries gamble on numbers; probably less than 1 in 100 books on the shelves in general institutions is used annually although specialized libraries enjoy a higher rate of utilization. Books in forms such as microfilms in single frames or reels can displace shelf contents and update editions with a saving in space and money.

Medical librarian training

Subsidies for continuing librarian education insure progress in library procedures. Librarians parallel medical school curriculum committees with plans for improvement. The new act guarantees continuing education for this special profession and is an incentive for others to enter the field.

Compilation and distribution of material

Data processing and computer programming are natural developments for libraries. Electronic methods are adapted readily to the traditional library. Better communications from the national library center to regional resource centers and satellite storage and service areas need funds to facilitate their cybernetic message.

Electronic ingenuity is not the problem. There is no limit to systems whereby visitors to libraries can get information about shelf contents. Almost as a jeremiad and a sigh for the past, it has been said: "At this stage in our journey through history...signals are flashing to tell us...that we are overloading our institutions with demands that exceed our capacity to perform. And this gap between expectation and performance widens every day."

Improvements in the basic resources of medical libraries

The hospital library is a special form of scientific literacy using and complementing the vocabulary of the profession that it serves. It has the potential to act as a visiting professor, technical associate, or even as a surrogate for a course in continuing medical education.

The development of regional medical libraries

The regional resource library is a tie binding the national library center and peripheral institutions. If Congress had done no more than to identify and to strengthen these ties with funds, the legislative actions almost might have been enough.

Cushing pointed out the danger of keeping books together on shelves. Books breed books but such associations have the semblance of legitimacy. Journals are brought together in like fashion; their offspring are more likely to be greater in numbers, and probably are not as legitimate.

Summation

The hospital library has a particular stake in the past, a hold on the present, and an obligation to the future. The Medical Library Association Act of 1965 permitted the hospital library to make plans with precision. Obviously expensive and indefinite stack-loading tendencies will go by the board. Data processing and programming are moving front and center. Libraries can be oriented to become centers of medical education utilizing all of the mechanics of an electronic age including closed-circuit television services and individual auditory and visual aides.

In the 12th century it was pointed out that those who stand on the shoulders of giants have a better view of the future. Libraries are literate man's shoulders. But even Prospero exclaiming: "My library was dukedom large enough" could feel assured because he had the income of a duchy as support. The Congressional Act did the same for libraries of later vintage.

Dr. Freeman presented this paper as a preamble for the first conference on "The Hospital Library," held under the auspices of the Pennsylvania Medical Society and a number of other sponsoring organizations. He has been a member of the Council on Education and Science and chairman of the Commission on Geriatrics.

'The Hospital Library--a partner of medical education' is the subject of meetings scheduled for Lecture Room C at Hershey Medical Center on April 14 and at Scaife Hall, University of Pittsburgh, on April 15. . . AAGP, AMA, and ACGP will award four credit hours for attendance

Podiatry and medicine — partners in health care

JOHN J. MARLETTE, D.P.M. CHAIRMAN

PPA Hospital, Medical and Professional Liaison Department

An effective exchange of ideas and information between the podiatry and medical professions has been initiated through meetings of the committee on relationships with allied professions of the Pennsylvania Medical Society and representatives of the Pennsylvania Podiatry Association (PPA). This liaison resulted from Resolution 69-29 adopted at the 1969 PMS House of Delegates.

The resolution calls for a dialogue between the two societies in areas of mutual concern toward the goal of high quality health care for patients. The podiatry profession recognizes the need to establish such a dialogue with the medical profession and its organized institutions.

Descriptively, podiatry is that branch of the healing arts having to do with the care of the foot. By definition and by statute of the Commonwealth of Pennsylvania, "Podiatry shall mean the diagnosis and treatment, including mechanical and surgical treatment, of ailments of the foot and those anatomical structures of the leg governing the functions of the foot and the administration and prescription of drugs incidental thereto. It shall include treatment of local manifestations of systemic diseases as they appear on the foot, but shall not include the amputation of the foot or leg or treatment of systemic diseases of any other part of the body."

The podiatrist bases his practice today on the same modern scientific principles of physiology, pathology, pharmacology, etc., as those adhered to in modern medical practice. Podiatry recognizes the contributions of those members of the medical profession who guided podiatry toward its present professional status.

Podiatry's educational standards is divided. The first level is a basic science-oriented curriculum covering two academic years in an accredited college. Upon successful completion of this course of study prospective podiatry candidates are screened by the admission test of the College of Podiatric Medicine. It is noteworthy that over half of the elected candidates have a baccalaureate degree or higher.

The professional curriculum is based on a minimum of 3200 hours of instruction distributed over four academic years. Instruction includes courses in anatomy, physiology, biochemistry, pharmacology, microbiology, neurology, orthopedics, radiology, pathology, and surgery. In the second year work is introduced in preclinical podiatry, foot roentgenology, and onychopathy. General courses in medicine, diagnosis, clinics, community health, dermatology, vascular diseases, anesthesiology, psychiatry, and internal medicine are required, along with podiatric surgery, hospital podiatry, and foot roentgenology.

During the third and fourth years of professional school, the student progresses in clinical and practical training. The establishment of internships and podiatric residencies for graduate students enhances his capacity to integrate his skills and training into the total care concept.

Recognizing that this is a critical period in planning for comprehensive health care and for improved delivery of quality care, the podiatry profession has assumed additional responsibilities in the form of peer review mechanisms, continuing education programs, and professional and public relations projects. Adoption and implementation of a code of ethics has long been the policy of state and national associations of podiatry.

The proper utilization of podiatry in the comprehensive care setting can help in alleviating the manpower shortage in the present system of delivery of health care.

The Joint Commission on Accreditation of Hospitals, Bulletin 44, spells out the means for establishment of podiatric services in accredited hospitals. This document streamlines the mechanism for expansion of multiphasic hospital services, a step toward comprehensive patient care.

Public Health Reports (Vol. 85, No. 9, 1970) publishes information under the title, "Podiatry Screening Project for Children in the District of Columbia." This endeavor is an example of preventive podiatry. On the other end of the scale, similar projects have been conducted in geriatric groups under U.S. Public Health Service sponsorship.

The proper utilization of podiatry in the comprehensive care setting can help in alleviating the manpower shortage in the present system of delivery of health care.

The Pennsylvania Podiatry Association is devoted to the concept of high quality health care in general, and quality foot care in particular. PPA will continue the promotion of this philosophy through interprofessional channels.

Abortion bill introduced

The issue of legalized abortion has been revived in the Pennsylvania Legislature with the pre-filing of a bill by Representative Gerald Kaufman of Allegheny County with the clerk of the House. The action was taken during that body's extended recess following passage of the 3½ per cent state income tax early last month. The bill would provide: "Any woman in this Commonwealth shall have the right to a medically safe abortion providing her request for abortion is made prior to completion of sixteen weeks of pregnancy."

The bill further says: "Only a physician duly licensed to practice medicine in this Commonwealth shall perform an abortion.

Surgical abortions shall be done only in an accredited hospital or other medical facility."

Abortions under this proposal would not be permitted in a doctor's office.

Co-sponsors of the bill are Reps. Charles Mebus, Montgomery County; Sarah A. Anderson and Norman S. Berson, both of Philadelphia County; Galen E. Dreibelbis, Centre County; and Jay R. Wells, III, Allegheny County.

The pre-filing of the bill during the recess means a delay in numbering the bill and assigning it to committee until the speaker of the house, Herbert Fineman of Philadelphia, is in Harrisburg. It is not expected that there will be quick action on the proposal in any event since a State Supreme Court ruling on a Centre County Court decision invalidating the present law as unconstitutional is expected soon. The present law prohibits "unlawful" abortion but does not specify what circumstances can make abortion legal.

New bill would prohibit ads

A bill prohibiting advertising by licensed practitioners of the healing arts in the Commonwealth, has been introduced, and referred to the House Committee on Professional Licensure. Supported by the Pennsylvania Medical Society, the bill H.B. 526, was introduced by Rep. Charles Mebus of Montgomery County, with co-sponsors Richard McClatchy, Montgomery; Gerald Kaufman, Allegheny; Norman Berson and Sarah A. Anderson, both of Philadelphia; Patricia Crawford, Chester; and James Prendergast, Northampton.

Aimed specifically at advertising by chiropractors, the bill reads in part: "No person licensed to practice medicine, dentistry, osteopathy, podiatry, optometry, chiropractic, or any healing art in this State, shall solicit persons to become patients by mail, card, newspaper, pamphlet, radio, television or any other media, or permit his services to be advertised; provided, however, that such person may publish a brief announcement of the opening of an office, or of any change of office location or changes of office hours, and may cause to be listed in the telephone directory in classified advertising sections thereof, his name, address, type of practice and office hours. Modest signs on doors, windows and walls of the licensee's office, or on the building in which he maintains an office, setting out his name, professional title in accordance with the law, office hours, and addresses, will not be considered as violations of this subsection...Each violation of subsection 1 of this Section shall be punishable by a fine of not less than $250 nor more than $1,000 or by imprisonment of not less than one month nor more than twelve months, or both."

Health secretary sworn in

J. Finton Speller, M.D., Philadelphia, was sworn in March 10 as Pennsylvania's Secretary of Health, following approval by the Senate just before its adjournment until March 29.

Dr. Speller succeeds Acting Secretary of Health John R. Clark, D.D.S., who continues as deputy secretary.

Dr. Speller, a practicing urologist, has held posts as assistant chief of urology at Mercy-Douglass Hospital and chief of urology at Philadelphia General Hospital.

For the past ten years, the new secretary of health has been associated with the Philadelphia Department of Health

DR. SPELLER

as clinical specialist in communicable disease control. He was also clinical consultant in the Philadelphia model cities comprehensive health program.

Dr. Speller's professional affiliations include membership in the Pennsylvania Medical Society, the Philadelphia County Medical Society, the American Medical Association, the National Medical Association, the Philadelphia Urologic Society, and the American College of Surgeons.

He is married to Dorothy R. Lynn, M.D., chief of dermatology at Mercy-Douglass Hospital. Dr. Lynn is also medical-specialist in the Philadelphia Department of Health. One of their three children, Marsha Speller, M.D., is an intern at Misericordia Hospital, Philadelphia.

Physician Shortage? Here Are Answers

The search for solutions to the problem of increasing primary health care services while maintaining high quality at the lowest possible cost has produced two obvious answers: (1) Increase the number of physicians by expansion of class size in established schools of medicine and by increasing the number of new medical schools. (2) Create a new breed of physician assistants to assume minor duties and responsibilities of physicians to permit the physician to become more productive in his more important responsibilities.

To date, insufficient time has elapsed to assess the effectiveness of these approaches. However, in this issue of PENNSYLVANIA MEDICINE there appears statistical data released recently by the AMA showing the continuing trend of physicians away from primary care in spite of an increase in total numbers of physicians. To reverse this trend medical schools must see the need to do so. Our non-syndicated columnist, George Rowland, rightfully emphasizes the role of the medical educators in determining the success of producing more physicians willing to undertake the responsibility of providing primary care. The selection of service-oriented students and the nurturing of these interests during their medical school years, are essential to the success of increasing the supply of primary physicians.

Physician assistants are still in the neonatal period. Former HEW Secretary Robert Finch popularized this concept by advocating the recruitment of medical corpsmen to stay in the civilian health care field after discharge. Another early advocate of the civilian medical corpsmen concept was Duke University. Duke instituted a program to train sub-physicians to serve under physician supervision in areas where physicians were in short supply. The idea has received favorable acceptance to the extent that Hahnemann Medical College and Hospital plans a two year program starting in the fall to train high school graduates to perform as physician extenders. Additional recognition has been given by the Veterans Administration through its establishment of a category that fits this concept and a starting salary of $8400 per year. Can this new breed reduce the need for physicians without sacrificing quality? Careful evaluation in the years to come will provide the answer.

In the search for answers little has been said about the other health care providers—dentists, podiatrists, pharmacists, optometrists and others. These seem to have escaped closer scrutiny on how they could contribute to the common goal of providing more time for the physician.

These groups have established facilities, faculties and licensing bodies that could provide a base for comprehensive review of their curricula and their patterns of practice and ultimate inclusion in the health care team. The scope of their services perhaps could be expanded and be coordinated to meet the needs of the future. Broadening and improving the inter-relationships between primary care physicians and these groups seems to me to be the next logical step in insuring the continuing comprehensive care the public demands.

DAS

Treating Venereal Diseases

Ampicillin for the treatment of gonorrhea is reported to be less effective than Penicillin G. In this issue of PENNSYLVANIA MEDICINE, on page 52, Drs. Leonard Shapiro and John Lentz report their experiences in treating 99 cases of acute gonococcal urethritis in males. They observed no failures. There have been reports in the literature that support their contention that Ampicillin is of value in penicillin G resistant cases of N. gonorrhoae. It should be noted, however, that no Ampicillin treatment dosage schedule has been established for syphilis and that careful follow-up of patients so treated is necessary to avoid missing those patients with mixed infections.

Venereal disease has become a source of increasing concern to the Pennsylvania Department of Health because of the marked increase in incidence among junior and senior high age groups. As the incidence increases more physicians will be called upon to treat these diseases, particularly gonorrhea and syphilis, and the need to remain up to date in their management is obvious.

Aqueous Procaine Penicillin G remains the treatment of choice in a dose of 2.4 million units. Smears and cultures should be repeated in forty-eight hours and if positive a repeat dose is necessary. A third dose is indicated if the smear and culture are still positive after another forty-eight hours.

In the event the patient is allergic to Penicillin, Tetracycline orally 500 mgm every 6 hours for a total dose of 3 grams or 12 doses is the preferred alternate drug regimen.

Evaluation of the success of therapy must not be overlooked. At least two negative smears and cultures are required before considering the patient cured. Follow-up serological tests for syphilis are essential to exclude a mixed gonococcal-luetic infection.

No patient with a venereal disease should be discharged until the physician has reported the case to the Pennsylvania Health Department for appropriate follow-up of contacts.

DAS

Let George Say It

The Breeding Of Family Physicians

GEORGE A. ROWLAND, M.D.
Millville

A few months ago an article by this author on the subject of admission to medical schools aroused considerable comment both favorable and otherwise. More to the point it directly resulted in responses from three Pennsylvania medical schools indicating that these schools at least are not guilty of the slipshod admission procedures which were noted in the article.

It is a source of satisfaction to me to know that these schools feel strongly enough about this point to have taken the trouble to place themselves on record in this way. Specifically, the article indicated that high grades are the overwhelming determinant as to whether an applicant is accepted by some medical schools; and that factors which might be more pertinent to his later success in the medical profession, but not pertaining to scholastic achievement, tend to be neglected.

After reading these letters and giving due consideration I have changed my point of view somewhat. The admission committee, after all, has a specific job to do. It would be futile for them to admit students to medical studies who would be unlikely to be able to graduate. As long as medical schools are organized much as undergraduate colleges, the kind of student who does well in college, other things being equal, is the one who will be most likely to succeed in medical school.

The young man or woman who learns to study effectively, who analyzes what the instructor wants from him, who produces it promptly and efficiently from his books and notes, who knows how to write learned papers, who takes good notes, and above all who has made himself competent at the delicate art of taking examinations, will be able to get through medical school. The fact that these qualities are of relatively little value to practicing physicians can scarcely be an important concern of an admission committee.

Now it is true that these same qualities continue to be valuable in all phases of the educational system. Teachers and researchers continue to study, take notes, write papers, and take examinations throughout their careers. On such factors will their future success be measured. It is no wonder that large proportions of medical graduates remain in fields where the talents that they have will be needed. In the meantime we continue to call these institutions medical schools and uninformed people expect them to turn out doctors who will take care of them.

We have a tremendous need for purveyors of medical care, primary physicians. The cities are full of doctors who have extensive training in highly specialized fields. In many instances the demand for the specialized service is inadequate and they must do a broader type of practice than that for which they are so well prepared. However much we may need narrow specialists, the obvious truth is that there are at the present time no institutions which recognize as their principal purpose the preparation of primary physicians. Admissions committees admit the students who are best adapted to the institutions they serve. It is no wonder that the proportion of graduates going into general practice has been forced down to less than twenty percent.

The Political Season

On a national level they're using the terms "medical Congress" or "health Congress." In fact, the first bill introduced into the House of Representatives when Congress convened in January was one amending the Social Security Act, making changes in both medicare and medicaid legislation.

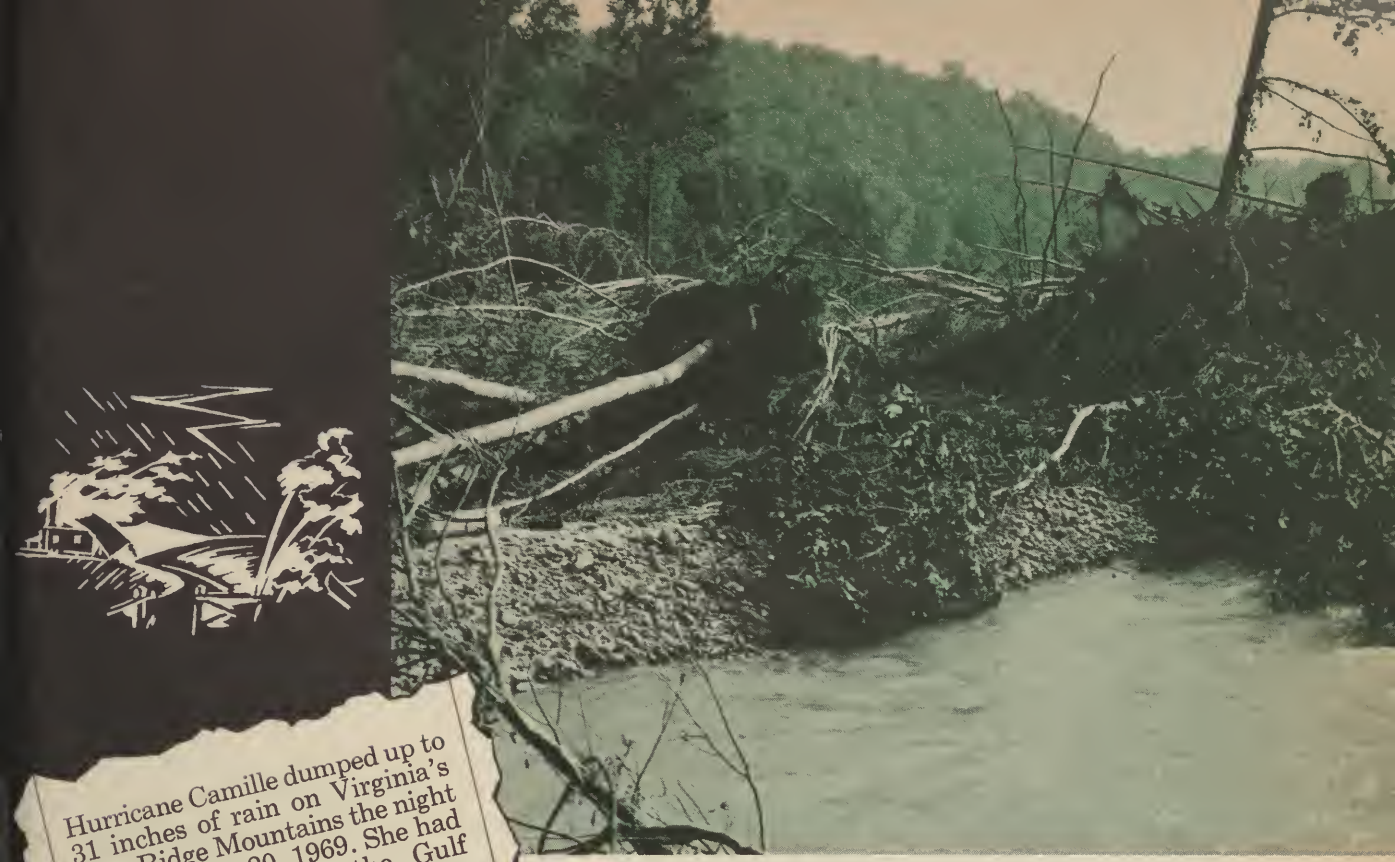
On the state level a number of bills have been introduced in both the House and Senate affecting the delivery of health care to the people of the Commonwealth.

Your State Society has as one of its primary goals keeping the membership informed of the status of pending legislation. If you are interested in further information on proposed legislation, the Pennsylvania Medical Society can provide it for you.

If you wish to communicate with your representatives your views on issues, follow these rules:

Be brief and to the point. Mention the bill by number in your letter. Keep the letter original—use your own words. State specifically the action you believe should be taken on the issue.

Keep in mind that your representative is interested in local opinion. He wants to make sure that the people "back home" are satisfied with his activities on the Hill.



Hurricane Camille dumped up to 31 inches of rain on Virginia's Blue Ridge Mountains the night of August 19-20, 1969. She had already devastated the Gulf Coast from Louisiana to Florida, halted her northward journey over Kentucky and Tennessee, then headed eastward over West Virginia and Virginia.
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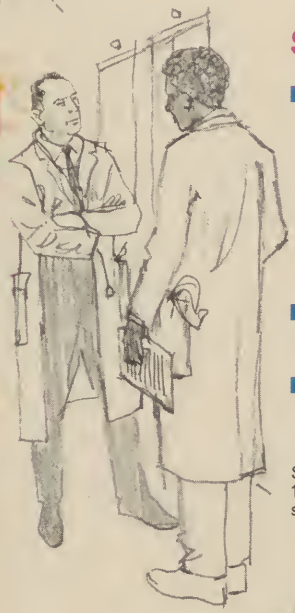

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PENNSYLVANIA MEDICINE cancer forum

Lag Time In Uterine Cancer Diagnosis.

Potential versus Performance

It is hard to believe it is more than fifty years since Papanicolaou reported his now famous vaginal smear test for the detection of uterine cancer, and almost twenty five years since his monograph, written in collaboration with Herbert Traut, laid down the guiding principles of the method. In a relatively short time its effectiveness was proved. It can "red flag" a cervical carcinoma years before anything is visible to the most searching unaided eye, and with an accuracy approaching perfection. It can do almost as well with cancer of the uterine fundus. It has the potential of eliminating deaths from this disease.

Such a test deserves the widest application. Yet it is variously estimated that less than 25 per cent of eligible women have ever had a Pap test. About 13,000 women will die of uterine cancer in 1971. The reason for inadequate use of the Pap test must be blamed on both patient and physician. Those women who visit physicians' offices or clinics must be informed of the test and convinced of the need to have it done. The women who for various reasons cannot or will not see a physician or attend a clinic must be reached, if possible, with the self-administered irrigation smear.

The physician, for his part, must be constantly alert to seek out those of his patients who have not had a Pap smear and pelvic examination. He should do these or see that they get done. If there is to be any deficiency let it not be due to the physician. Well then:

WHO SHOULD HAVE A VAGINAL SMEAR?

1. All women over age 20.
2. Women of any age who have had sexual experience.

HOW OFTEN SHOULD IT BE DONE?

1. Annually up to age 35, then every six months.
2. Before starting contraceptive measures.
3. After treatment for uterine carcinoma, whether it be surgery or radiation.

Dr. Papanicolaou developed the test for uterine cancer which bears his name

HOW ARE SMEARS MADE?

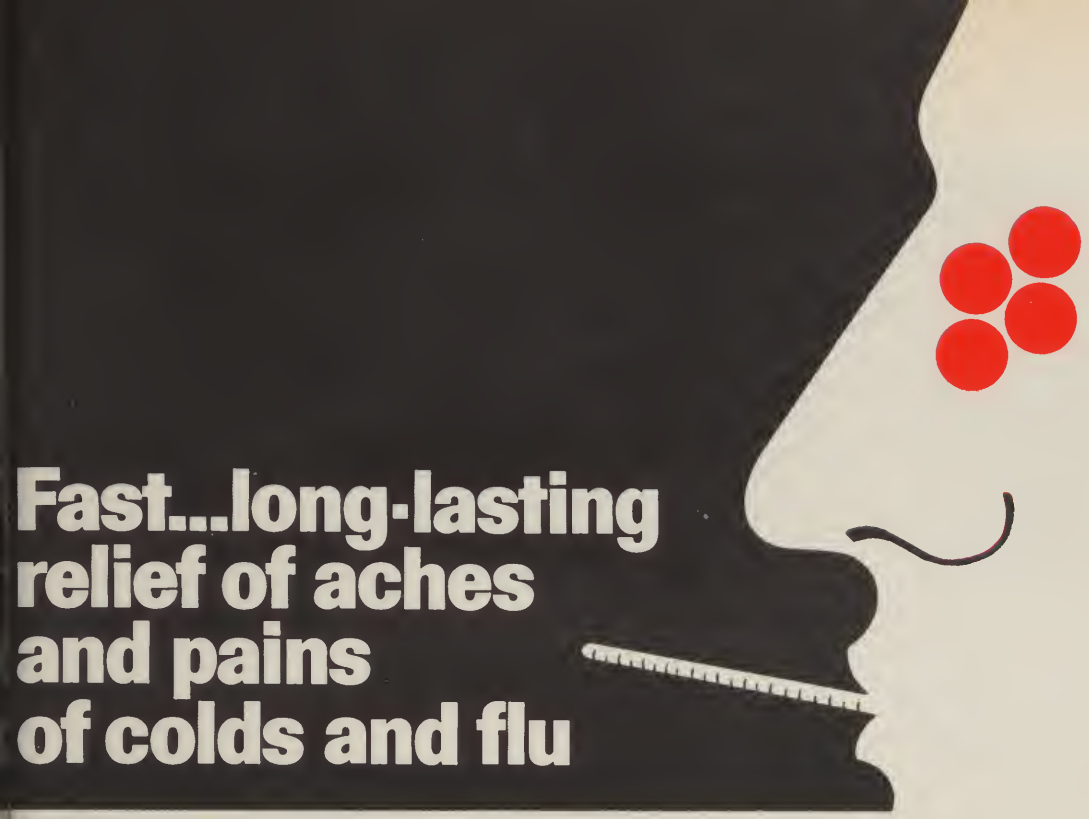
1. Minor details may vary within the cytopathologist interpreting the smears but these are the basic rules.
2. The patient should not have douched or taken a tub bath within twenty four hours of the test.
3. Use no lubricant jelly before test is completed.
4. Have all equipment at hand so there is no delay in applying fixative solution to the wet smear.
5. Aspirate the first specimen with glass tube and rubber bulb, placing the tube tip into the posterior vaginal pool. Blow the aspirate onto a glass microslide, spread smear with the side of the tube and immediately cover with fixative. Either drop-on or spray fixative can be used. Most laboratories provide their physicians with such fixative.
6. Expose cervix with dry speculum and scrape with wooden scraper or wipe cervix with cotton-tipped applicator. Try to get the mucus plug which is particularly rich in cells. Smear material on a second slide and fix immediately as before. Slides are now ready to be sent to the laboratory. You can now proceed with the usual bimanual pelvic examination.

WHO INTERPRETS THE SMEARS?

This should be done only by an experienced cytopathologist. Pennsylvania has excellent cytologic facilities and you can probably be served by your local laboratory.

The above method can be easily fitted into the office routine and add no more than a minute or so to examining time. By thus examining *all* our women patients the lag between potential and performance of the Pap smear can be surely reduced.

CANCER FORUM — presented cooperatively by the PMS Council on Education and Science. The Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.



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Progestin Therapy For

Cancer Of The Uterine Corpus

GEORGE C. LEWIS, JR., M.D.
Philadelphia

THE WIDE variety of clinical challenges associated with primary, persistent, or recurrent cancer of the uterine corpus requires familiarity with a fairly broad therapeutic spectrum if patients are to be offered the best potential for tumor control or palliation. Surgery combined with irradiation appears most effective for the patient with tumors limited to the corpus, although advocates of surgery or irradiation alone have demonstrated comparable results.[14] More advanced disease still limited to the pelvis may be managed by extensive intracavitary and external irradiation or by radical surgery with a reasonable chance for long term tumor control. The most difficult problems facing the gynecologist are those in which the disease has spread beyond the pelvis, persisted despite definitive treatment, or recurred. In such instances it is not unusual to give consideration to some form of medical management either alone or combined with some form of surgery or radiotherapy. Experience to date suggests that progestins offer very low toxicity[4,9] and acceptable response rates[2,7] in contrast to other forms of chemotherapy that are limited by hazardous side effects. It is the purpose of this presentation to explore situations in which they may or may not be of value.

The development and production of progestins has permitted high dose hormonal therapy to be applied from a few weeks to indefinite periods of time with apparent subjective and objective response. In 1959 Kistner[6] reported that carcinoma *in situ* could be controlled by progestins. In 1961 Varga and Henrikson,[15] and Kelley and Baker,[5] reported that 17 α hydroxyprogesterone caproate (Delalutin®, Squibb) could alter the progress of adenocarcinoma and adenocanthoma. A number of subsequent reports have confirmed these observations relative to this agent.[2,3,4,7,9,11,13,16,17] The dose has varied from several hundred milligrams to ten grams a week. Duration of therapy has varied from a few weeks to many years. The principal limitation of this agent has been the

fact that it must be given intramuscularly.

A second hormonal preparation that has gained acceptance[1,4,7,9,12,13] is a 6 α-Methyl-17-α-hydroxyprogesterone acetate (Provera®, Upjohn). Quite a variety of programs have been employed. Some have ranged from 100 mgm. to 800 mgm. or more a month.[7] In others 400-500 mgm. weekly has been given using the 'Depo' form.[8] The oral preparation has been employed in doses of 100-300 mgm. a day.[1] Another oral medication not generally available is Medrogestone.[10,18] This has been used in doses varying from 20 to 1000 mgm. daily. Dimethisterone, a drug that may be administered orally has been employed in 100 mgm. doses.[19] A number of other agents have been reported as effective in tumor control, e.g. AY62022, ethisterone, Enovid® (Searle),[12] etc., but the experiences have been limited to very small series of patients.

On the basis of the reports dealing with progestins it has been generally shown that subjective responses, such as diminished pain, leukorrhea, and bleeding,[9] have occurred in approximately 75 per cent[11,12] of patients. Objective responses have varied from 19 per cent to more than 50 per cent.[6,13] Pulmonary and osseous lesions[2,10,13] seem most responsive while lesions located in previously irradiated tissues seem most resistant.[10] Well differentiated tumors appear to repond more favorably than do poorly differentiated ones.[17] Better responses have been noted in young patients in contrast to older individuals.[10] Because several weeks are required to obtain a response, the use of progestins should be limited to those who will live long enough for the expected benefits. A minimum of three months of therapy is suggested before progestin failure should be considered likely.[1,9]

The initial investigations[5,6,15] into the hormone therapy of endometrial cancer touched upon atypical hyperplasia, *in situ* cancer, or persistent and recurrent malignancy. Direct endometrial cavity application of a progestin was reported as a primary therapeutic procedure, but the adjuvant use of a progestin on a double blind investigational basis was not undertaken until 1962 when a program entitled "Endometrial Adjuvant Chemotherapy"[8] was undertaken. Through the cooperative efforts of a large number of institutions, patients with adenocarcinoma and adenocanthoma limited to the uterus were subjected to standard procedures of surgery or surgery plus intracavitary irradiation. To these standard procedures was added the weekly injection of 500 mgm. of Depo Provera® (Upjohn) or a placebo for fourteen weeks. Between April 1, 1962, and November 30, 1968, 607 patients were enrolled and so randomized that almost equal numbers of patients received progestin or placebo. The findings in terms of two to seven years of follow-up do not provide any evidence to support the adjuvant use of a progestin under the conditions set up in the study. Not enough patients have reached the five year limit to draw final conclusions. The data at present suggest that the

TABLE I

Well and Moderately Differentiated Adenocarcinoma of the Uterine Corpus

Clinical Observations and Results

Patient Number	Initials	Age	Primary or Recurrent Sites of Involvement	Associated Therapy	Objective Response	Duration and Comment
1.	F.L.	59	Recurrent* "frozen" pelvis	6 m.e.v. external beam to pelvis	Yes	2 months still in remission
2.	M.P.	62	Recurrent** liver	None	Yes	5 months regrew beginning at six months
3.	E.M.	104	Primary Stage IV lungs, abdomen, abdominal wall, inguinal, cervical, axillary nodes	None	No	died 1 week after initial injection
4.	D.W.	54	Recurrent* bladder	None	Yes	25 months - regrowth 26 months now controlled by Cytoxan
5.	P.W.	72	Recurrent* pelvis and lungs	6 m.e.v. external beam to pelvis	Yes	4 months, then deceased Cerebro-vascular accident
6.	E.T.	68	Recurrent*** pelvis	None	Yes	8 months - rapid regrowth at nine months

* Primary therapy surgery alone
** Primary therapy surgery and irradiation
*** Primary therapy external irradiation alone

TABLE II

Poorly Differentiated Adenocarcinoma of the Uterine Corpus

Clinical Observations and Results

Patient Number	Initials	Age	Primary or Recurrent Sites of Involvement	Associated Therapy	Objective Response	Duration and Comment
1.	M.C.	70	Recurrent** pelvis	6 m.e.v. beam	No	Patient developed abdominal and supraclavicular lesions during third month of hormone therapy
2.	M.D.	53	Recurrent* pelvis	6 m.e.v. beam	Yes	5 months - still in remission
3.	S.C.	70	Recurrent** generalized abdominal	None	No	3 months therapy with no response
4.	E.D.	72	Recurrent*** pulmonary	None	Yes	4 months, then patient failed to receive Depo Provera for 2 months. Recurrence responded to I.V. HN_2 briefly
5.	P.S.	44	Primary pelvis	6 m.e.v. beam	Yes	6 months - still in remission received Depo Provera for 2 months only
6.	R.F.	63	Primary lungs, bladder, vagina, parametrium, uterus, cervix	None	No	Lived 6 weeks
7.	K.B.	33	Primary periaortic, inguinal nodes, frozen pelvis	6 m.e.v. beam	Yes	2 months
8.	M.M.	84	Primary vagina, parametrium, inguinal nodes	6 m.e.v. beam interstitial vulvar and vaginal radium intracavitary radium	Yes	Nodes regrew after 5 months
9.	M.K.	55	Recurrent** periureteral, omentum, pelvic and periaortic nodes	None	No	1 month of therapy tumor progressed patient died
10.	M.R.	55	Recurrent*** inguinal skin and nodes supraclavicular nodes	None	No	2 months of therapy tumor progressed patient died

* Primary therapy surgery alone
** Primary therapy surgery and irradiation
*** Primary therapy irradiation alone.

inal five year survival results will be igher than originally anticipated; they ill be so high apparently, that it ill be impractical to expect a study f similar design to ever accumulate nough patients to demonstrate at ast a 3 per cent difference between rogestin and placebo even though is might be so. It is possible that me other study format might have emonstrated an effect from a proestin, e.g. larger doses, a different ormone, more prolonged therapy, etc., but the present study does not provide, to date, any basis for the primary adjuvant use of a progestin.

In situations other than the adjuvant use of progestins, there appears to be accumulating evidence of the effectiveness of these hormones for cancer of the uterine corpus. Certainly, when a patient is found to have both local pelvic disease and distant metastases, hormone therapy should be considered. The extrapelvic disease may respond to a progestin. Local irradiation or whole pelvic irradiation, may satisfactorily control the extensions of the tumor within the boney pelvis. Thus, on occasion, the combination of irradiation and hormone therapy may be more effective than either one alone. Care should be taken to avoid therapy of the essentially terminal patient because of the time factors required for response. If some immediate response is required, e.g. to control hemorrhage, it may be more advantageous and practical to use ir-

radiation, packing, ligation, etc.

The patient who has persistent or recurrent malignancy poses a need for decisions before progestins are employed. In selected cases with limited lesions, local irradiation or excision may prove very effective. If irradiation has not been previously employed, it may be valuable in eliminating post-surgical recurrence. However, when radiotherapeutic or surgical control is out of the question, or when the disease has gone beyond the pelvis, progestins should be given the first trial basically because of the minimal side effects.

At Hahnemann Medical College and Hospital, beginning in 1962, Depo Provera was employed, without the use of a control, for selected malignancies arising from the endometrium. This study series did not constitute part of the "Endometrial Adjuvant Chemotherapy" program, although it did include one patient who developed a recurrence one year after primary therapy under that program. Between January 1, 1962, and January 31, 1970, there were placed in the specially selected group sixteen cases of adenocarcinoma, two of malignant mixed Mullerian cell tumors and one endometrial sarcoma. The protocol called for the initial injection, i.m. of 800 mgm. of Depro Provera. Thereafter 400 mgm. (400 mgm/cc) was given once weekly until the tumor (1) showed no evidence of response (generally a minimum of three months), (2) killed the patient, or (3) the tumor escaped from control. Two patients did not fit the protocol but they are included in this report. One (E.M., Table I) died one week after the first injection from her extensive malignancy. The second with disease clinically limited to a frozen pelvis received injections for eight weeks (P.S., Table II). She received in addition, 6,000 rads of external beam irradiation from a 6 m.e.v. linear accelerator. Her referring physician, feeling that she was 'cured' stopped her hormone therapy. She has been apparently free of disease for six months to date. Table I indicates the clinical observations and results for patients receiving Depro Provera when the lesion was either a well or moderately differentiated adenocarcinoma. The age range was from 54 to 104: The oldest patient, the only one failing to respond and living only one week, was essentially terminal and it was thought that hormone therapy was the least rigorous procedure to offer the patient. D.W., the patient with a bladder lesion, proven by biopsy, is still living ten years after total hysterectomy for carcinoma of the corpus. The bladder lesion was discovered three years after the hysterectomy and treated by 6,000 rads irradiation from a Cobalt 60 source. Four years of control resulted. When the lesion reappeared Depo Provera provided twenty-five months additional control. A year ago the tumor reappeared despite hormone therapy. Immediate regression, and control to date has been achieved with Cytoxan therapy.

Table II presents a similar set of observations for patients with poorly differentiated adenocarcinoma. In contrast to the first group with five out of six objective responses, the poorly differentiated lesions responded five out of ten times. It should be noted that for the entire group of adenocarcinomas, seven out of ten patients with objective response had additional pelvic irradiation of 5,000 to 6,000 rads in five to six weeks. One of the seven patients (P.W.) did not have irradiation therapy to her lung metastases. Two other patients (K.B. and M.M.) received definitive pelvic irradiation but only minimal radiation therapy to other sites. The three patients who responded without the aid of additional irradiation had lung, liver, or bladder metastases. For the entire group of ten responsive lesions, the duration of objective remission varied from two months to twenty-five months. Most of the responses were relatively brief, two to six months. Response was defined as 50 per cent reduction in two dimensions. Usually

TABLE III

Malignant Mixed Mullerian Cell Tumor
Endometrial Sarcoma

Clinical Observations and Findings

Patient Number	Initials	Age	Primary or Recurrent Sites of Involvement	Associated Therapy	Objective Response	Duration and Comment
MALIGNANT MIXED MULLERIAN CELL						
1.	R.R.	57	Primary well differentiated lungs, vagina, abdomen, inguinal nodes, liver	6 m.e.v. beam Thiotepa	Yes	6 months - lesion stable, then progressed despite chemotherapy
2.	V.H.	61	Recurrent** poorly differentiated abdomen	minimal 6 m.e.v.	Yes	6 months - lesion stable, then progressed
ENDOMETRIAL SARCOMA						
1.	J. .M.	32	Recurrent* pulmonary metastases	None	Yes	1 year - changed to Provest controlled after 2 years of Provest-1 year no therapy

* Primary Therapy Surgery Alone
** Primary Therapy Surgery and Irradiation

it was complete disappearance of a mass.

Table III indicates the clinical observations and results for three unusual lesions. The malignant mixed Mullerian cell tumors did not regress. They did cease rapid growth patterns established just prior to therapy. Control was maintained in both cases for only six months. Of usual interest is the patient with endometrial sarcoma.* One month after surgical treatment she was found to have multiple pulmonary metastases. These responded to Depo Provera. After one year the patient objected to injections. She was changed to Provest, 30 mgm. a day, P.O. The patient has not developed evidence of reactivity of her tumor after two years on the oral medication and a subsequent year with no therapy.

The results for this series of nineteen patients suggests that Depo Provera may be of value in the control of malignancies arising from the endometrium. The series by itself is too small to warrant rather positive conclusions but associated with the reports of others lends strength to the claims of value for progestins. It must be stressed that a number of the responders had supplemental associated external megavoltage irradiation. The extremely satisfactory response for these patients suggests that therapists should consider whenever possible additional therapeutic modalities when progestins are utilized. For most of the patients, who showed an objective response, the duration of the response has been essentially very brief. Generally, these patients whose tumors responded, experienced rapid regrowth of tumor when they escaped from control. Additional therapy usually could not be supplied because of the rapid downhill course or because the patient delayed reporting until the recurrence had become widespread.

Obviously the transient nature of the responses reported in this series and in many reports, leaves much to be desired. Further investigation is needed to be able to more definitely identify those who may respond and to uncover some means of therapy that offers a very high incidence of prolonged control.

* *Gifford Grimm, M.D., Neptune, N. J., has very kindly supplied basic data and follow-up for this patient.*

Summary

Depo Provera, 800 mgm., and then 400 mgm. weekly thereafter, was administered to nineteen patients with malignancy arising from the endometrium. Sixteen of the patients had an adenocarcinoma. Five of the six patients with well or moderately differentiated lesions responded objectively. A similar response was seen in five out of ten patients with poorly differentiated lesions. Objective response lasted from two months to twenty-five months. Seven of the ten patients with objective response had been associated with irradiation therapy. Three additional unusual cases are reported. Responses in general were discouragingly brief. Further research is needed to identify patients who will respond and to establish new approaches that will provide a high incidence of response for prolonged periods of time. Mention is made relative to the adjuvant use of Depo Provera in conjunction with standard methods of primary treatment of cancer of the uterine corpus. On the basis of a study that is still incomplete, the adjuvant use of Depo Provera appears to provide no benefits beyond those usually anticipated for surgery alone or surgery combined with intracavitary irradiation. □

Dr. Lewis is professor and chairman of the department of obstetrics and gynecology at Hahnemann Medical College and Hospital. He is president of the Philadelphia Division of the American Cancer Society. Depo Provera provided for this study through the courtesy of Samuel W. Stubbs, M.D., of the Upjohn Co. Kalamazoo, Mich.

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Oral Ampicillin In The Treatment Of Gonorrhea In Public Health Clinics

LEONARD W. SHAPIRO, M.D.
JOHN W. LENTZ, M.D.
Philadelphia

TABLE 1

Penicillin Susceptibility of Randomly Cultured Strains of N. gonorrhoeae in Philadelphia in 1965 and 1968

mcg./ml. of Penicillin	Number of Cultures Susceptible	
	1965	1968
0.0025	0	0
0.005	4	2
	52%	26%
0.01	29	9
0.05	58	13
0.1	30	7
0.15	14	9
0.2	12	14
0.3	12	19
0.4	4	7
0.5	6	4
0.6	5	1
0.7	1	3
0.8	0	0
0.9	0	2
1.0	0	1
1.1	1	0
Total Cultures	176	91

Source: National Communicable Disease Center.

IN 1965 a study of the susceptibility of *N. gonorrhoeae* to penicillin was conducted using strains cultured from patients in Philadelphia public health clinics. Ninety-one of 176 strains, or 52 per cent, were inhibited by 0.05 mcg./ml. or less of penicillin. When another survey was made in 1968, it was found that only twenty-four of ninety-one strains, or 26 per cent, were inhibited by the same concentration of penicillin (see table I). This decrease in the sensitivity of *N. gonorrhoeae* to penicillin, noted here and in other parts of the world for several years, led to our interest in doing a clinical study of ampicillin, a synthetic penicillin which has been shown to be highly active *in vitro* against strains of gonococci which are relatively resistant to pencillin G.[1,2]

Polycillin®, Bristol Laboratories
Amcill®, Parke-Davis

TABLE 2

Treatment Results and Disposition of Patients

	Number N. gonorrhoeae isolated	Cure	Failure	Reinfected	Lost to follow-up	Totals
Ampicillin capsules group	28	96	0	3	85	212
Procaine penillin G injection group	33	104	3	4	56	200
Totals	61	200	3	7	141	412

Although ampicillin has been commercially available for seven years, there have been no extensive studies published in which the recommended 500 mg. t.i.d. oral dosage has been used. Marmell et al.[3] reported that sixteen patients treated with this regimen were cured. Heinemann and Vinikoff[4] gave the drug in 250 mg. oral doses every six hours for six doses and had 103 cures out of 111 patients treated. Other investigators using various dosages have found ampicillin effective in treating patients who failed on penicillin.[5,6,7] In the present study we compare the effectiveness of 500 mg. of ampicillin three times daily to that of 2.4 million units intramuscular procaine penicillin G in 210 patients from the clinic populations where the sharp rise in penicillin resistance had been noted.

Materials and Methods

Patients in this study received either 1,500 mg. of ampicillin trihydrate one 500 mg. capsule three times daily for one day, or a single injection of 2.4 million units of procaine penicillin G. The treatment regimen to which a patient was assigned depended on which week he entered the study. All those entering during the first week were put into the ampicillin group, those entering the next week were put into the penicillin group, and so on until approximately 200 patients had been assigned to each group.

Four hundred and twelve males with clinical symptoms of acute gonorrheal urethritis were admitted to the study as they presented to one or the other of two Philadelphia public health clinics cooperating in the study. They ranged in age from thirteen to sixty-six years, and their weights ranged from 110 pounds to 233 pounds. Patients were excluded from the study only if they had (a) a history of sensitivity to penicillin or a history of allergies which caused the physician to prefer a non-penicillin antibiotic, (b) a disease other than gonorrhea which required treatment with a chemotherapeutic agent, (c) a history of previous antimicrobial treatment for the present infection, or (d) a positive serological test for syphilis.

Diagnosis was confirmed in 351 patients by histories of recent sexual contact and positive smears made from urethral discharge specimens. Treated patients were instructed to return three days later for follow-up examinations and to abstain from sexual activity until then.

Of the 351 treated, 141 failed to report for follow-up examinations, leaving 210 in whom treatment could be evaluated. During the second visit, another smear was made if a patient's urethral discharge persisted. If it was positive and reinfection could be ruled out, the treatment was recorded as a failure. Patients without urethral discharge were recorded as cures.

Results

Study results are summarized in table II. In the group of 111 treated with 2.4 million units of procaine penicillin G there were three treatment failures; in the group of ninety-nine treated with 1,500 mg. of ampicillin there were no treatment failures. No serious side effects were noted in either group.

Drs. Shapiro and Lentz are from the section of venereal diseases control, division of epidemiology, community health services of the Philadelphia Department of Public Health.

Conclusions and Comment

The results of this study indicate that 1,500 mg. of oral ampicillin is effective in treating acute gonococcal urethritis in males from a population in which gonococcal resistance to penicillin has risen sharply.

Odegaard reported in a brief correspondence in 1962 that although ampicillin showed a weaker affect against most strains sensitive to penicillin G, it was conversely more active against the strains least sensitive to penicillin G. Reyn and Bentzon supported this finding in a more complete report in 1968. Thus it would seem that as the incidence of strains with decreased sensitivity to pencillin increases in a population, ampicillin will become a more valuable antibiotic. □

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Treatment Of Parkinsonism With Amantadine Hydrochloride

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Dr. Diamond is presently at Queens Hospital in Long Island, New York.

AMANTADINE hydrochloride (Symmetrel®, du Pont de Nemours) is an anti-A-2 flu agent which has been used recently in the treatment of Parkinsonism. The efficacy of this agent was discovered serendipitously in a patient with Parkinsonism who had received amantadine hydrochloride to prevent Asian flu. Schwab et al.[1] reported that of 163 patients with Parkinsonism, 66 per cent showed some improvement on amantadine hydrochloride in doses up to 100 mgs. twice a day. Of the patients with improvement, 58 per cent had persistent improvement and the rest worsened after initial treatment, for a sustained improvement rate of 38 per cent.

This report involves thirty-six patients treated with this medication at the Episcopal Hospital. The results are much less satisfactory. Only 11 per cent of the patients showed a sustained improvement. Of the thirty-six patients treated, thirty-four presented with either generalized or Hemi-Parkinsonism of the idiopathic variety (Table I).

TABLE I

Types of Patients Treated

Idiopathic Parkinsonism	34
Parkinsonism and Cerebrovascular Disease	1
Hereditary Cerebellar Tremor	1

One of the patients had a hereditary cerebellar tremor and the other had Parkinsonism plus cerebrovascular disease.

Twenty-Four patients were treated with amantadine hydrochloride alone or in conjunction with such anticholinergic drugs as trihexyphenidyl hydrochloride or benztropine mesylate (Table 2). Ten of the Parkinsonian patients were treated with levodopa[2] and amantadine hydrochloride together. The latter were patients who did not have optimum improvement with levodopa and amantadine hydrochloride was added in an attempt to improve their status. Amantadine hydrochloride was maintained at 100 mgs. twice a day in all patients.

One patient insisted upon taking four capsules a day contrary to his instructions. Of the twenty-four pa-

TABLE II

Therapy and Results in Patients with "Pure Idiopathic Parkinsonism"

	Success	Failure
Amantadine Alone	2	10
Amantadine Plus Anticholinergics	2	10
Amantadine Plus Levodopa	0	10*

*Represents failure for amantadine hydrochloride to improve levodopa effect.

ients with idiopathic Parkinsonism reated with amantadine alone or mantadine plus anticholinergic drugs, our showed sustained improvement vhich is a success rate of 17 per cent.)f the ten patients with idiopathic 'arkinsonism taking levodopa and mantadine combined, none showed mprovement over levodopa alone. Four atients had subjective improvement ut there was no evidence of objective mprovement. The demented patient vith long tract signs and the patient vith hereditary cerebellar tremor were ot improved. The former patient was iso on levodopa and the latter on mantadine alone.

The failures fell into two categories.)ne group (six patients) demonstrated nitial improvement which was sus-ained for several weeks but then radually plateaued and returned to he initial clinical status: the other group :wenty-six patients) showed no im-rovement at all. The improvement in nost cases was not marked but one atient did progress from severe ak-nesia to an almost normal clinical tate, returning in several weeks to his nitial state. Four patients developed de effects and are listed as failures. 'hese included agitation, nightmares, aresthesiae and anxiety. In the four uccesses reported, two had a Hemi-Par-insonian syndrome, one had bilateral gidity and akinesia, and the other had ilateral tremor. All of these were im-roved markedly and sustained the nprovement over five months. One of nem had to stop levodopa because of rthostatic hypotension. The levodopa ad improved his tremor before being iscontinued. Amantadine hydrochlo-ide alone has sustained the improve-ient for six months. The patient with kinesia and rigidity could not get out f a chair alone and had a gross tremor n the right side before treatment. He lso had a mild left hemiparesis secondary to a right chemothalamectomy done in the past. He improved markedly on amantadine hydrochloride, the akinesia and tremor completely remitting. This patient refused to maintain the dosage at twice a day. He felt he needed four a day in order to sustain the clinical effect. He has remained improved for over six months. This patient was initially tried on levodopa but could not tolerate the drug because of severe confusional states and angina.

Summary

In summary, our success with amantadine hydrochloride has not approached the success rate of that reported by the original investigators. We have found that amantadine hydrochloride will not improve the patient who has reached maximum effect of levodopa. It is true that amantadine hydrochloride does improve the signs of Parkinsonism in a small minority of patients. There is no known biochemical or physiological data at the present time that would explain why this is true. It is interesting to note that in a number of failures initial improvement was present but transient. Amantadine hydrochloride does have a minor place in the treatment of Parkinsonism. It can be used in patients who cannot tolerate levodopa.

The major question of this report is why is there such a difference between our results and those reported by Schwab et al.? We feel that further investigation by other groups are indicated to settle this question. □

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Side Effects Of L-Dopa Treatment

JACK GREENBURG, M.D.
Philadelphia

L-DOPA HAS been shown to be the most effective treatment for Parkinson's Disease thus far. The past two years have proven very exciting for those physicians who have been using the drug and for the thousands of patients that have been treated. The purpose of this report is to underscore the side effects of the drug with the hope physicians will approach this drug with great respect.

Since October, 1968, 150 patients with Parkinson's Disease have been treated at the Episcopal Hospital. The results of the treatment have been presented to the Philadelphia Neurological Society at a symposium on the Treatment of Parkinson's Disease with L-Dopa, College of Physicians, Philadelphia, Pennsylvania, May, 1969. The results of the study are similar to all of the previously published reports.[1,2,3]

This report concerns the first 84

TABLE 1

Side Effects

	Group 1 38 patients	Group 2 46 patients
1. Nausea	24	20
2. Chorea	17	19
(Mouth only)	(6)	(4)
(Mouth and Limbs)	(11)	(15)
3. Vomiting	14	16
4 Confusion	14	1
5. Hallucinations and Nervousness	11	11
6. Orthostatic Hypotension	6	4
Symptomatic	1	1
7. Incessant Talking	2	2
8. Anorexia		2
9. Weight Loss		3
10. Increased Tremor		1
11. Depression		4

patients treated in this study. (See Table 1) There were 43 men and 41 women with an average age of 60 years. The most common side effect was nausea which was experienced by 44 patients. The second most common side effect was a movement disorder (dyskinesias) which was experienced by 36 patients. Ten patients showed movements of the mouth and tongue only, and 26 patients had oral dyskinesias and movements of the limbs. The third most common side effect was vomiting which was experienced by 30 patients. Fifteen patients had episodes of confusion. Hallucinations were present in 22 patients. Orthostatic hypotension was seen in a total of 10 patients with only two patients being symptomatic. Of these two patients, only one had to discontinue the drug because of syncopal attacks upon standing. The other patient eventually became asymptomatic. Two patients talked incessantly. Anorexia was seen in two patients, weight loss in three, increased tremor in one and and depression in four patients. As experience with the drug grew, side effects decreased in frequency.

There were no consistent laboratory abnormalities. One patient had a transient elevation of the SGOT and ten patients had elevated uric acid which subsequently became normal without any change in treatment. On four patients, twenty-four hour urine uric acid was measured before and after treatment, there was no significant change. It has been suggested that the elevation of uric acid is a result of a testing procedure rather than a true elevation of uric acid. Electroencephagrams were performed on patients before and after treatment and there was no consistent change.

The slower one gave the drug, the fewer the side effects. The dose had to be built up very gradually over a period of weeks, otherwise the side effects were more severe. It was noted that after months on the medication many of the patients could be treated with a lower dose of L-Dopa and the side effects would be obviated. This is especially true with nausea, vomiting and dyskinesia. Females did not tolerate the drug as well as males. The females were begun on 250 mg. capsules, B.I.D. and the males were begun on 500 mgs., B.I.D. Serial electrocardiograms were performed and there were no arrhythmias. Other groups[2,3] report cardiac arrhythmias occurring with the use of L-Dopa and this problem remains unsolved. There were two sudden deaths in this group, but autopsies were not performed and the cause of death will remain unknown. A third patient died of carcinoma of the esophagus which was proven at autopsy.

One interesting effect was recently reported by this author.[4] This was a series of four patients who fell and fractured their hips. These patients had had a remarkable response to L-Dopa and upon assuming normal or even excessive activity, such as playing football and dancing, the fractures occurred. Since the original observation, another patient has fractured his hip. The patients are being advised to resume previous activities slowly.

Recently, L-Dopa has been hailed as an aphrodisiac. When questioning the patients in this group, only 2 per cent have noted an increase in their potency. It is the opinion of this author that this is a secondary affect of overcoming their Parkinson's Disease and depression rather than being a primary aphrodisiac affect.□

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Metastatic Tumors Involving The Heart and Pericardium

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THE INCIDENCE of metastatic tumor involving the heart and pericardium during a ten year period at the Thomas Jefferson University Hospital was reviewed. During this period ending January 1, 1969, 3,710 autopsies were performed. Of these, 1,164 autopsies were on patients with malignant tumors and 1,047 of these autopsies showed residual malignancy with metastasis. Evaluation of the clinical histories, charts, and histologic findings showed gross and microscopic metastatic involvement of the heart and pericardium in 147 of the 1,047 autopsies (14.1 per cent).

No clinical pathognomonic features of metastatic cardiac disease could be determined from a review of medical records of these patients for evidence of myocardial infarction, friction rubs, cardiac murmurs, significant electrocardiographic changes, radiographic abnormalities or any antemortem diagnostic procedures referrable to the heart.

Recent reports have indicated an increased incidence of metastatic tumor involving the heart.[1,2,3] We were fortunate in being able to compare our series with a series previously reported from this institution in 1942. That series[4] reported 35 to 640 tumor

TABLE I

Primary Tumor Sites

	Cases	Diffuse Metastasis	Cardiac Metastasis
Adrenal	3	3	1
Bladder	26	17	1
Breast	104	99	15
Colon	105	87	2
Esophagus	38	31	5
Gallbladder/Liver	36	24	2
Hodgkin's	64	63	3
Kidney	25	24	5
Larynx	18	16	4
Leukemia	111	111	22
Lung	257	218	44
Lymphosarcoma	36	35	6
Melanoma	24	24	6
Mesothelioma	6	5	2
Myeloma	15	15	0
Nasopharynx Sinuses Head and Neck	25	21	2
Osteosarcoma	10	10	3
Ovary	35	35	0
Pancreas	47	45	6
Prostate	28	18	0
Sarcoma	24	24	7
Stomach	57	54	3
Testicle	10	10	1
Thymoma	3	3	1
Thyroid	7	5	3
Tongue	9	7	1
Uterus	14	13	1
Cervix	26	22	1
Vagina	2	2	0
Miscellaneous: Penis, Ampulla of Vater, Ureter	9	6	0
	1,164	1,047	147

TABLE II

Heart Weight and Symptomatic Cases

	Heart Weight		Symptomatic Cases
Greater	350-400 grams	26 cases	Lung (2)
	401-450	14	Hodgkins, Mesothelioma
	451-500	5	Lung (2)
	501-550	7	Thyroid
	551-600	0	
	601-650	1	Leukemia
	810	1	Larynx
		54 cases	9 symptomatic

cases with cardiac involvement for an incidence of 5.5 per cent in contrast with our incidence of 14.1 per cent.

Various attempts at explanation o the increased incidence have beer presented.[5] New therapeutic regimens may prolong life and allow a malignancy more time to metastasize. Clinicians have an increased awareness of the possibility of neoplastic involvement of the heart particularly when symptomatic. More microscopic sections from the heart, particularly with leukemia cases where gross involvement may be absent, may increase the reported incidence.

A primary neoplasm of any tissue may have subsequent cardiac metastasis.[1,2,3,4,5,6,7,8] Metastatic tumor from the lung, the breast, and from leukemia resulted in the highest incidence in our series.

The antemortem diagnosis of metastatic tumor to the heart has been recorded.[5,7,8] Seven of our 147 cases had clinically suspected metastatic cardiac disease. These suspicions were based on the development of known metastatic visceral disease, pericarditis, sudden appearance of arrhythmia, intractable congestive heart failure, previously unrecorded murmurs, and clinically suspected myocardial infarction.

There were sixty-nine electrocardiographic abnormalities recorded. They included pericarditis, atrial abnormality, atrial fibrillation, right bundle branch block, complete heart block, atrioventricular dissociation and myocardial infarction.

A diagnosis of malignant neoplasm was not made until autopsy in four of our cases. The longest survival from the time of tumor diagnosis until death was twelve years. Over one third of our cases (65) developed metastatic cardiac involvement within six months from the time of diagnosis. Sixteen patients of the 147 survived over five years from the time of diagnosis.

The highest incidence of metastasis was from bronchogenic carcinoma (44 of 218 cases). See table I. Neoplastic involvement of the heart may occur by direct extension, lymphatic spread, and through the blood stream. Neoplasms with a relatively high percentage (over 20 per cent) of cardiac involvement included kidney,[9] larynx.

TABLE III

Histological Type of Tumors Metastatic to Heart

Adenocarcinoma	48	(Breast 15 cases)
Squamous Cell	23	(Lung 11 cases)
Anaplastic	22	(Lung 19 cases)
Leukemia lymphoma (31)		
	12	Lymphocytic leukemia
	6	Myelogenous leukemia
	4	Monocytic leukemia
	4	Reticulum Cell Sarcoma
	3	Hodgkins
	2	Lymphosarcoma
Sarcoma (22)		
	6	Melanoma
	3	Osteosarcoma
	2	Leiomyosarcoma
	2	Synovial sarcoma
	2	Fibrosarcoma
	2	Rhabdomyosarcoma
	2	Mesothelioma
	1	Testicular
	1	Thymoma
	1	Neuroblastoma
Transitional Cell	1	
	147 cases total	

leukemia,[10,11] lung,[12] melanoma,[13] mesothelioma, osteosarcoma, and sarcomas (rhabdomyosarcoma, leiomyosarcoma). Primary neoplastic sites with a low rate of cardiac involvement included bladder, colon, gall bladder, liver, Hodgkin's disease, myeloma, ovary, prostate, stomach, uterus, and cervix.[14] Neoplasms arising beneath the diaphragm infrequently metastasized to the heart in this series.

For purposes of classification, we divided cardiac involvement into pericardium, pericardium and heart, and heart only. Fifty cases involved only the pericardium; forty-six involved the pericardium and heart; and fifty-one involved only the myocardium. Table IV shows the relation between the metastatic tumor site, symptoms and antemortem diagnosis.

Twenty-eight of our 147 cases had hearts weighing from 400 to 810 grams. See table II. It appears that, when the heart is enlarged due to a

TABLE IV

Symptomatic Cases

Primary Site	Tumor Dx. to Death	Antemortem Diagnosis	Signs/Symptoms	Cardiac Involvement
Hodgkins	6 months	No	Presented with SUC Syndrome and Pericardial Friction Rub	Pericardium/Epicardium, left ventricle/right atrium
Kidney	1½ months	No.	600 cc. Pericardial Effusion	Pericardium/Myocardium
Kidney	12 months	No	Pericarditis (EKG)	Pericardium/Epicardium
Larynx	15 months	No	Myocardial Infarction. Pulmonic Stenosis	810 gram Heart-markedly replaced by tumor.
Leukemia	3 months	No	Right bundle branch block	Septum/Myocardium
Leukemia	36 months	Yes	Acute Pericarditis	Pericardium/Myocardium
Lung (Anaplastic)	At PM	No	Acute Congestive Heart Failure. Tumor Diagnosed at Autopsy	Pericardial Effusion 300. Epicardium.
Lung (Anaplastic)	17 months	No	Right atrial abnormalities. EKG.	Complete Replacement with tumor.
Lung (Anaplastic)	22 months	No	Pericarditis (EKG)	Pericardium
Lung (Anaplastic)	1 month	No	Right bundle branch block	150 cc. Pericardial Effusion. Epicardium/Myocardium
Lung (Anaplastic	6 months	Yes	Pericardial Effusion 2^0 to tumor	Pericardium/Myocardium
Lung (Anaplastic)	2 months	Yes	Pericardial Friction Rub	Pericardium
Lung (Squamous cell)	1 month	Yes	Cardiac Tamponade. Pulsus Paradoxicus.	Pericardium/Epicardium/ Myocardium.
Lung (Alveolar)	4 months	Yes	X-ray Large Pericardial Effusion	1450 cc. Tumorous Pericardial Effusion.
Lymphocytic lymphosarcoma	1 month	Yes	Complete Heart Block	Massive Myocardial Involvement
Mesothelioma	24 months	No	Pericardial Effusion	500 cc. Effusion. Pericardium/ Epicardium/Myocardium
Osteosarcoma	8 months	Yes	Pericardial Friction Rub	Pericardial
Thyroid	96 months	No	Pericardial Effusion	920 cc. Effusion. Pericardium/ Epicardium.

TABLE V

Cardiac Metastasis as a Direct Cause of Death

Kidney	600 cc. Pericardial Effusion	Died on Admission
Larynx	Tumor Thrombus Coronary Artery	Died 6 weeks after Clinical Dx. of Myocardial Infarction
Lung	Cardiac Tamponade Pulsus Paradoxicus	Multiple Tumor nodules 200 cc. Effusion
Lung	1450 Serosanguinous Pericardial Effusion	
Lymphosarcoma	Complete Heart Block	Lived one day - Massive Myocardial involvement
Thyroid	920 cc. Hemopericardium	

tumor, there is a greater likelihood of significant symptoms.

Twenty patients had, at autopsy, pericardial effusion of greater than 50 cc.'s. Cytological examination of the effusion showed malignant cells in only one case. The volume of effusion is increased when both the visceral and parietal pericardium are involved. In our series of eighty-eight male and fifty-nine female patients, no age group was free of metastatic cardiac involvement. The histological patterns in our cases are summarized in table III.

After review of all cases with metastatic cardiac involvement, eighteen were found to have signs and symptoms which should have suggested the antemortem diagnosis of metastatic neoplasm. See table IV. Only seven of these cases were suspected antemortem. As previously stated, only one diagnosis was verified cytologically. The incidence of significant symptomatic metastases is 12.3 per cent (i.e. 18 out of 147).

Tumor metastasis was directly responsible for the patients' death in only six cases (4.1 per cent). See table V. In none of the 147 cases was the heart the only site of metastasis. Solitary cardiac metastasis has been reported.[5]

Summary

A study of metastatic disease involving the heart at the Thomas Jefferson University Hospital over a ten year period was performed.

147 of 1,047 metastatic neoplasms involved the heart. Of the 147 patients, 18 presented signs and symptoms referrable to cardiac involvement which should have been determined antemortem. Metastatic cardiac involvement was clinically suspected in seven of these patients. Pathognomonic signs and symptoms of metastatic cardiac involvement were not found.

The total number of cardiac metastases is much higher than the clinically significant number of metastases. In only 6 of the 147 cases do we feel that the cardiac metastasis was the direct cause of death.

The primary site of disease most commonly metastasizing to the heart was the lung.

Dr. Harrer, above, recently became associated with Our Lady of Lourdes Hospital, Camden, N.J., after having been assistant professor of pathology at Thomas Jefferson University Hospital. Dr. Lewis, below, is associate professor in pathology there. The authors wish to acknowledge with gratitude the secretarial assistance of Miss Barbara MacTough and Miss Ray Fingerhood.

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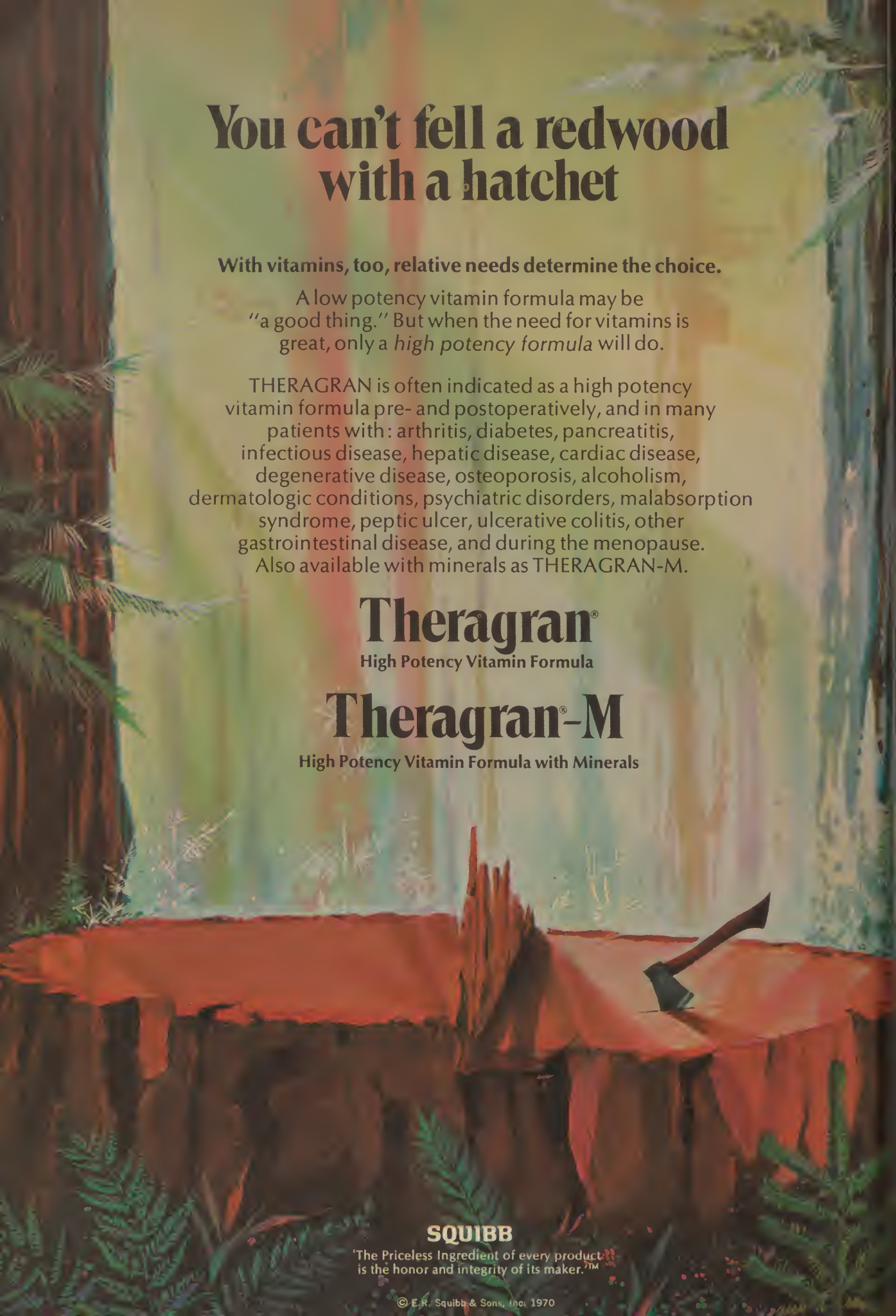
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Current Status Of Rheumatic Fever
Part One

C. Robert E. Wells, M.D., professor of pediatrics, Temple Medical School, Philadelphia, is questioned by William G. Leaman, Jr., M.D.

What is rheumatic fever?

Rheumatic fever is a disease which occurs in certain susceptible individuals following an untreated or inadequately treated streptococcal infection. It may involve most of the tissues of the body, but the heart, joints and central nervous system are especially inflamed. An antigen-antibody reaction is suspected.

Why any concern about rheumatic fever (RF) and rheumatic heart disease (RHD)?

"Approximately 100,000 new cases of RF and RHD occur each year. In 1968 about 16,000 deaths from acute RF and chronic RHD were reported in the U.S.A. In 1965 there were over 100,000 hospital discharges (excluding military and VA hospitals) in which RF or RHD was the primary diagnosis, and 133,000 additional discharges in which they were the secondary diagnosis. The estimated cost of physicians' visits for RF and RHD in fiscal 1969 was about $28 million." (Circulation: May, 1970).

It is estimated that there are 1.5 million cases of RHD in the United States today. Since the peak incidence of acute RF is in patients between the ages of five and fifteen years, many of whom will have chronic RHD, the cost of medical care (hospitalization, convalescence, rehabilitation, surgery, medicines, physicians) over the next twenty to forty years runs into thousands of dollars for one patient. *Much of this can be prevented.*

In what clinical forms may rheumatic fever present?

It is seen as (a) *Migratory Polyarthritis* involving the larger joints (knee, wrist, elbow, ankle). Severe pain on palpation or movement is present in addition to signs of heat, redness and swelling. (b) *Chorea or St. Vitus Dance* with emotional instability and involuntary movements to the point of inability to talk intelligibly, walk safely or dress or feed oneself. (c) *Carditis* which may involve endocardium (valvular insufficiency and later on stenosis), myocardium (enlargement with poor function), or pericardium (pain, not observed alone). This involvement may be severe enough to cause heart failure. (d) *Erythema Marginatum,* an evanescent, serpiginous rash on the trunk and extremitis (post-streptococcal) and *subcutaneous nodules*; firm movable lumps over the extensor surfaces of elbows, wrists, knees, even scalp are also listed as major manifestations but are usually associated with a, b, or c.

How is the diagnosis of rheumatic fever made?

This is a clinical diagnosis. The above criteria (Modified Jones) are useful as a guide. There is no specific laboratory test.

What are some of the pitfalls in the diagnosis of rheumatic fever?

(a) Mistaking the muscular "growing pains" frequently occurring at night to be the same as the objective signs of migratory polyarthritis (heat, redness, swelling, pain). (b) Mistaking the frequently occurring innocent murmur to be an organic murmur due to rheumatic valvulitis. If uncertain, a consultation may help. (c) Overinterpreting laboratory findings. A sedimentation rate is non-specific evidence for the presence of many active infections, one of which may be rheumatic fever. An elevated antistreptolysin O (ASO) titre indicates a recent streptococcal infection and not necessarily acute rheumatic fever.

Does rheumatic fever always involve the heart?

No. There may be only migratory polyarthritis or chorea from which there is complete recovery. However, some of these patients may have evidence of rheumatic heart disease in later years. It is not known whether this represents a slow, smouldering, unrecognized process or damage occurring during a recurrence.

What is a "touch" of rheumatic fever?

It is probably a wrong diagnosis. One should be certain of the diagnosis before labeling a patient. Once the diagnosis has been made, there is no certain way of erasing the diagnosis in the future. When the diagnosis of rheumatic fever is made, this involves prophylaxis, regular medical check-ups, and may affect job opportunities and insurance.

Is rheumatic fever contagious?

No, but the streptococcal infection which precedes an attack of rheumatic fever may be transmitted to close contacts at home or at school.

William G. Leaman, Jr., M.D., edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.

His makeup is unique by tradition.
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In the world of entertainment, a clown's makeup remains the exclusive property of its originator. Time has established that tradition. In the treatment of ulcers and other gastrointestinal complaints, time has established Pro-Banthine as a tradition too.

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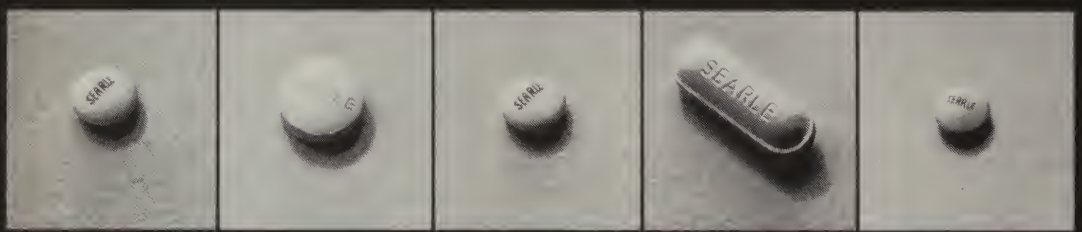
(propantheline bromide)

the traditional ulcer treatment



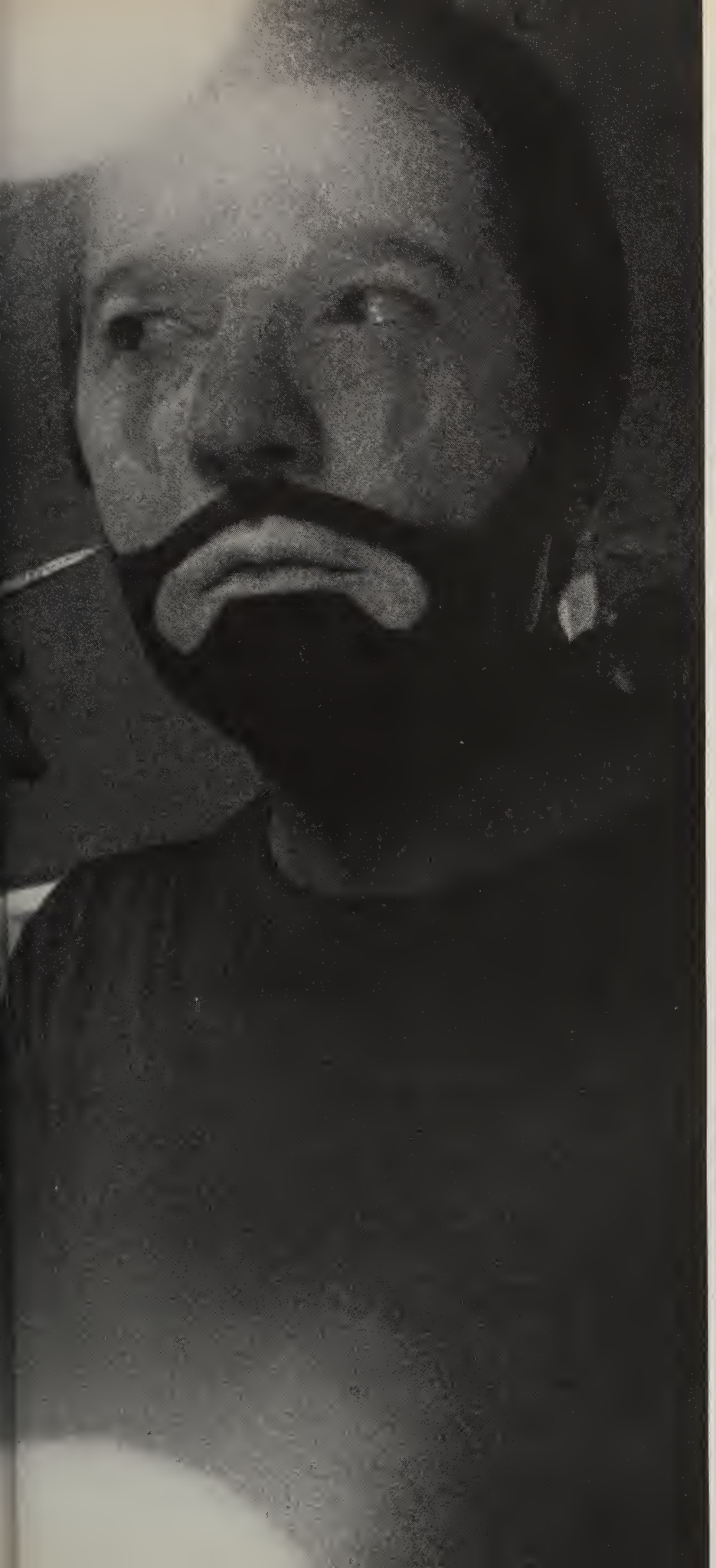
Pro-Banthine 15 mg. propantheline bromide

Pro-Banthine 15 mg. propantheline bromide with Dartal 5 mg. thiopropazate dihydrochloride

Pro-Banthine 15 mg. propantheline bromide with Phenobarbital 15 mg. warning: may be habit forming

Pro-Banthine P.A. 30 mg. propantheline bromide in time-release form

Pro-Banthine 7½ mg. propantheline bromide Half Strength



Pro-Banthine®
(propantheline bromide)

Indications: Peptic ulcer, gastroenteritis, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.

Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

Pro-Banthine® 15 mg.
(propantheline bromide)
with
Dartal® 5 mg.
(thiopropazate dihydrochloride)

Indications: Peptic ulcer, spastic constipation, nonspecific gastritis, functional gastrointestinal disorders, pylorospasm, hyperhidrosis, irritable bowel syndrome, mucous or ulcerative colitis, functional diarrhea.

Contraindications: Glaucoma, severe cardiac disease.

Warnings: Pro-Banthine with Dartal should not be administered to patients who are under the influence of barbiturates, alcohol or narcotics. The drug should be administered cautiously to epileptic patients or those in depressed states, patients with liver disease and to pregnant women. Hypersensitivity to Dartal may occur rarely in patients with known sensitivity to similar drugs.

Side Effects: Dryness of the mouth, mydriasis, hesitancy of urination; less commonly extrapyramidal (restlessness, dystonia and signs of pseudoparkinsonism such as muscular rigidity, fixed facies, tremor, ataxia, festinant gait and drooling), parasympatholytic (blurred vision, xerostomia, hypotension, nasal congestion and constipation) and curare-like (loss of control of voluntary muscles, particularly the muscles of respiration) reactions. Rarely, leukopenia or allergic purpura. A generalized erythematous skin reaction may occur. Side effects characteristic of phenothiazines such as grand mal convulsions, altered cerebrospinal proteins, cerebral edema, potentiation of the effects of atropine, heat or phosphorus insecticides, autonomic reactions, endocrine disturbances, reversed epinephrine effect, hyperpyrexia or pigmentary retinopathy may theoretically occur but have not been reported with Dartal. Severe hypotension following recommended doses occurs more commonly in patients who are also afflicted by other medical disorders such as mitral insufficiency or pheochromocytoma, and particular attention should be paid to such a possibility although this has not been observed with Dartal.

Adult Dosage: One tablet three times a day.

Pro-Banthine® 15 mg.
(propantheline bromide)
with
Phenobarbital 15 mg.

Warning: May be habit-forming.

For *Indications, Contraindications, Precautions, Side Effects* and *Dosage* see Pro-Banthine. In addition, phenobarbital should be administered with caution to patients with liver disease, mental disturbances or a significant degree of hypoxia.

Pro-Banthine P.A.®
prolonged acting brand of propantheline bromide

For *Indications, Contraindications, Precautions* and *Side Effects* see Pro-Banthine.

Dosage Form: Capsule-shaped, compression-coated, peach tablets of 30 mg. for oral use.

Dosage: The recommended initial dosage is one tablet in the morning and one at night.

084

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Guide his hand to quality and economy

Specify Deltasone® 5 mg. (prednisone, Upjohn)

an economical prednisone that's made a name for itself

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

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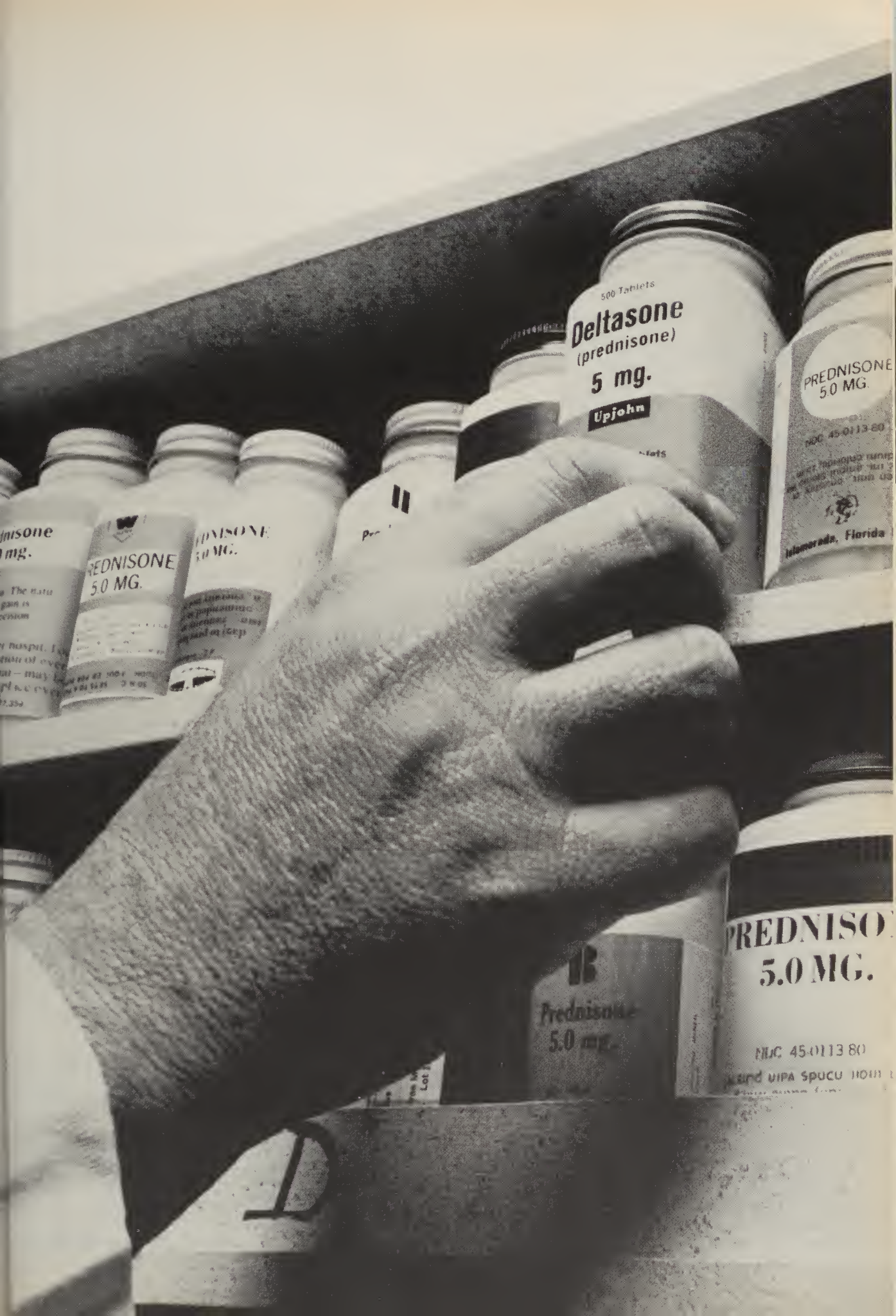
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Deltasone
(prednisone)
5 mg.
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PREDNISONE
5.0 MG.
Prednisone
5.0 mg.
5.0 MG.

DELTASONE® TABLETS—2.5 & 5 mg.
(prednisone, Upjohn)

The potency of prednisone exceeds cortisone in glucocorticoid and anti-inflammatory activity by about five times on a weight basis, but is considerably less active than cortisone in mineralocorticoid activity.

Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. *Important:* Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptomatically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9-alpha-fluro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoids during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis, an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and, whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angiitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

Supplied: 2.5 mg., scored—bottles of 100 tablets. 5 mg., scored—bottles of 100 and 500 tablets and cartons of 100 tablets in foil strips.

For additional product information, consult the package insert or see your Upjohn representative.

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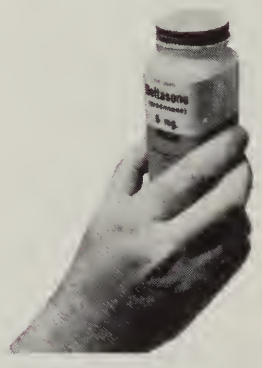

Deltasone® 5 mg. (prednisone, Upjohn)

an economical prednisone that's made a name for itself

To the Editor:

As one who is concerned with rising hospital costs and even more so with those who are upset by rising costs, how does one go about seeking and bearing witness to the truth?

If true hospital costs were made known, acknowledged as such, and agreed upon, maybe then and only then can we understand and define the problem and seek its solution.

Since solutions are only as good as the facts upon which the problem is based let us examine hospital costs from an analysis of figures submitted by representative non-governmental, non-profit, general short term stay Allegheny County hospitals and published in the August 1, 1968 issue of "Hospitals", a Journal of the American Hospital Association.

Study of figures would indicate that as the size of hospitals increase costs increase. However, I am not sure that this is necessarily the impact of the more and varied services offered by the larger institutions as it is that overall efficiency tends to decrease with "bigness" (this may be a natural phenomenon over which there is little control).

Next, looking at the spread of average costs per admission in the smaller hospital bed group as compared to the larger hospital bed group one sees a 36 per cent increase in the latter group.

However, the greatest spread in cost from one hospital to another (in this instance Suburban General Hospital and Presbyterian University Hospital) is 112 per cent.

If we look at the average cost per patient day we realize an increase of only 15 per cent between the smaller and larger hospitals with the greatest individual hospital spread being 85 per cent.

It is also interesting to note that depending upon the method of ranking (either according to cost per admission or cost per patient day) the position of a hospital within its group may change. The most striking example of this is Magee Hospital which on the basis of cost per admission costs $103 less than the average for the group but if ranked according to cost per patient day would be the highest in the group. This observation certainly raises serious questions as to which index may be validly used when comparing costs of similar hospitals.

Most hospitals have a personnel to patient ratio of 2.5 to 1 with their payrolls accounting for approximately two-thirds of hospital costs. Rising costs in this area have sometimes been blamed for the general rise in overall hospital costs. Yet we note that, in some of the most expensive hospitals, payroll as a per cent of total costs is among the lowest for the group (St. Margaret's Hospital, Presbyterian University Hospital, and Montefiore Hospital).

It might also be logically assumed that cost per patient day should vary inversely with length of hospital stay but this is not borne out by the data.

Needless to say the problem of hospital costs needs much clarification. But is hospital cost, which essentially is the price tag on room and board, nursing care, diagnostic and therapeutic services, the real problem or is the problem that of putting a price tag on health as if it were some tangible product readily defined and easily measured?

In reality we have no way of measuring the product, if health is a product, and even if one were able to quantitate it how does one qualitate it?

Juries have been known to award hundreds of thousands of dollars for loss of life, limb, sight, mental anguish and total and partial disability. Many similar awards are often made out of court. If these "settlements" are justified how much more is a life, limb, or sight worth when these are saved?

What price tag do you put on the relief of suffering and anxiety of patients which generally follows admissions to hospitals or visits to physicians for complaints real or imagined?

We are being told that this nation is in a health crisis. This crisis, I propose, stems not from the imperfections of the existing health care system, which is constantly undergoing change but rather stems from the attempt of one imperfect, albeit coercively powerful system, to plan and direct the course of the other.

Since scientists tell us that every effect must have a cause, the government must now look around for some scapegoat—preferably some placid, successful professional group which is feeding off of the fruits of inflation and is not likely to kick up too much of a fuss. Since any educated and informed American knows that American medicine is not the best, and is not the envy of the entire world—the logical sacrificial lambs should be physicians and hospitals which form the core of American medicine.

Hospitals and physicians are now denounced as wickedly causing the price rise and the government conveniently uses these attacks as an excuse for extending its control of health in America under the guise of "public interest."

Many national health insurance schemes have already been proposed and many more will come, and the American public, God bless them, looking for "pie in the sky" and "something for nothing" will have no choice but to accept one of them.

Is it too late for those directly concerned with the health of America to coordinate medicine's diverse activities without coercion?

Joseph M. Behun, M.D., Department of Radiology
Mercy Hospital, Pittsburgh

To the Editor:

Reading "Reflections on the Feast of the circumcision" by Dr. Rowland arouses my own reflections. My memory goes back to the time when I was a Battalion Surgeon in the Second World War. One of our duties was commonly known as "Short Arm Inspection." I can still remember the disgusting sights and odors which greeted me and my associates when the foreskin was pulled back. In those days dentists were impressed into this duty, and one of them, who was not Jewish, was heard to remark "My God! Don't you ever clean that thing?"

As regards maiming the male infant, Jewish men have been maimed like this for over two thousand years and do not have appeared to be the worse.

Morris Rosen M.D.
Philadelphia

INTERMITTENT COURSES

Listed below are courses of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, contact the director at the address given in the course listing.

CODE KEY

C—Consecutive days
I—Intermittent
O—Circuit
PG—Postgraduate Traineeship
S—Designed for full-time specialists
AMA—AMA Accredited Institution
CES—Council on Education and Science, Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
Hershey—Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Pitt—University of Pittsburgh, School of Medicine
Penn State—Pennsylvania State University
Temple—Temple University Health Sciences Center
U. of Pa.—University of Pennsylvania, School of Medicine
Woman's—The Medical College of Pennsylvania

GASTROENTEROLOGY

Philadelphia; January 14—April 18, 1971

I/AMA—SYSTEMATIC REVIEW OF GASTROENTEROLOGY; by U. of Pa.; at Lecture Room A; 4 hrs. ea. day; 1 day ea. week; 8 weeks; 32 hrs. AAGP credit requested; $150 fee. Contact Aaron D. Freedman, M.D., Assoc. Dean, U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

GENERAL MEDICINE

Aliquippa-Rochester Hosps. (rotation); third Wed., ea. mo.
Altoona Hospital; fourth Thurs. ea. mo.
Greensburg (Westmoreland Hosp.); first Tues. ea. mo.
Johnstown (Conemaugh Valley Mem. Hosp.); first Thurs., ea. mo.
Natrona Heights (Allegheny Valley Hosp.); second Tues. ea. mo.
Uniontown Hospital; last Mon. ea. mo.
Washington Hospital; first Wed. ea. mo.

O/I—DIAGNOSIS AND MANAGEMENT OF HYPERTENSION; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin P. Shapiro, M.D., Project Dir., 501 Flannery Bldg., 3530 Forbes Ave., Pittsburgh 15213.

Allentown; September 2, 1970—May 5, 1971

I—TEAM APPROACH TO PATIENT CARE (Fall-Winter Education Program); at Sacred Heart Hosp.; first Wed. ea. mo.; 3 hrs. each day; AAGP credit applied for. Contact Vincent J. Jerant, M.D., Chm. House Staff & Educ., Sacred Heart Hosp., 4th & Chew Sts., Allentown 18103.

Altoona Hospital; October 15, 1970—May 20, 1971

I—AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every other Thurs.; 7 months; 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 17, 1970—May 20, 1971

I—AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Luke's Hosp.; third Thurs. ea. mo. (except December); 8 mos.; AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford/Kane; October 20, 1970—May 18, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; alternately at Bradford's Penn Hills Club and Kane Manor; third Tues. ea. mo., 18 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Chester; September 8, 1970—May 25, 1971

I/AMA — POSTGRADUATE SEMINARS FOR PHYSICIANS: BY Hahnemann; at Crozer-Chester Med. Center; 2 hrs. AAGP credit approved ea. day; 38 days; a day ea. week. Contact James E. Clark, M.D., Chief of Med., Crozer-Chester Med. Center, 15th & Upland Sts., Upland, Chester 19013.

East Stroudsburg: October 17, 1970—April 17, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at General Hosp. of Monroe Co., third Sat. ea. mo., (except December); 18 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Erie; September 17-18, 1970—May 13-14, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Vincent's Hosp.; Thurs. eve. and Fri. morn.; approx. once every three weeks; 39 hrs. AAGP credit applied for. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Gettysburg; January 12—April 21, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; at Annie Warner Hosp.; alternating Tues. and Wed. every other week; 24 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Harrisburg; November 10, 1970—May 11, 1971

I/AMA—CONTINUING EDUCATION COURSE; by Hahnemann; at Harrisburg Polyclinic Hospital; once ea. month. Contact David A. Smith, M.D., D.M.E., Harrisburg Polyclinic Hosp., Harrisburg 17105.

Hazleton State Gen. Hosp.; September 2, 1970—May 26, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hazelton Branch of Luzerne Co. Med. Soc., and Hosp.; 1½ hrs. per day; 1 day per week; 36 weeks; 30 hrs. AAGP credit. Contact Robert L. Gunderson, M.D., Dir. of Med. Educ., Hazelton State Gen. Hosp., Hazelton, Pa. 18201.

Johnstown; November 24, 1970—May 25, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Conemaugh Valley Memorial Hosp., fourth Tues. ea. mo. (except Jan.); 6 sessions, 2 hrs. ea.; 12 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lancaster General Hosp.; September 22, 1970—May 18, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; 1 day ea. week; 18 weeks; 3 hrs. AAGP credit applied for ea. session. Contact John H. Esbenshade, Jr., M.D., Dir. of Medical Educ., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17601.

Lebanon; November 3, 1970—May 4, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Quentin Riding Academy; first Tues. every other month; AAGP credit requested. Contact John Killough, Ph.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lewistown Hospital; February 10—April 14, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every Wed., ea. mo.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Lock Haven Hospital; October 21, 1970—May 5, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first and third Wed. ea. mo.; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Meadville; September 2, 1970—May 5, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; first Wed. ea. mo. at Spencer Hospital; 30 hrs. AAGP credit applied for; $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Philadelphia; September 14, 1970—May 17, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Methodist Hosp.; first and third Mon. ea. mo. (except holidays); AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Pottsville; September 24, 1970—May 27, 1971

I/AMA—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; at Good Samaritan Hosp.; fourth Thurs. ea. mo. (except Nov., Dec. and Apr.); 2 hrs. ea. day. Contact Norman M. Wall, M.D., Dir. of Med. Educ., Good Samaritan Hosp., E. Norwegian and Tremont Sts., Pottsville 17901.

Pottsville Hospital; September 3, 1970—June 3, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; first Thurs. ea. mo.; 10 mos.; 2 hrs. AAGP credit approved per session. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

Pottsville Hospital; First Thurs. of every mo., beginning September, 1971

I—CONTINUING MEDICAL EDUCATION; by Pottsville Hospital; 2 hrs. ea. day; 1 day ea. mo.; 0 hrs. AAGP credit requested. Contact E. W. Cubler, M.D., D.M.E., Pottsville Hospital, Mauch Chunk & Jackson Sts., Pottsville 17901.

Reading: September 22, 1970—May 25, 1971

I—1970-71 CONTINUING EDUCATION PROGRAM; at St. Joseph's Hosp.; fourth ues. ea. mo. (except December); 8 hrs. AAGP redit requested. Contact Kenneth M. Schreck, .D., Med. Dir., St. Joseph's Hosp., 215 Walnut t., Reading 19603.

Reading; October 21, 1970—April 21, 1971

I/AMA—CONTINUING EDUCATION COURSE; Hahnemann; at Community General Hosp., nce ea. month. Contact Paul K. Stolz, M.D., M.E., Community General Hosp., 135 N. Sixth reet, Reading 19601.

Wyre: August 24, 1970—June 14, 1971

I—ROTATING SEMINARS (10 sessions Cardiology; 5 sessions Dermatology; 11 sessions Endocrinology; 13 sessions Hematology; 7 sessions eurology; 8 sessions Psychiatry; 4 sessions Radiation Therapy; 9 sessions Urology—ephrology); at Robert Packer Hosp.; 1 hr. ea. ssion; hour-for-hour AAGP credit approved. ontact Paul C. Royce, M.D., Ph.D., Dir. Med. uc., Robert Packer Hosp., Guthrie Square, yre 18840.

Scranton; October 21, 1970—May 19, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson d Penn State; at Mercy Hosp.; 1 day a month; 8 onths; 24 hrs. AAGP credit approved. Contact hn H. Killough, Ph.D., M.D., Assoc. Dean, Jefson, 1025 Walnut St., Philadelphia 19107.

Sellersville; September 23, 1970—June 16, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann and Grandview sp.; at Grandview Hosp.; fourth Wed. ea. mo. cept December); 18 hrs. AAGP credit quested. Contact D. Henry Ruth, M.D., Dir. of d. Educ., Grandview Hosp., Sellersville 18960.

Sewickley Valley Hospital; April 7—28, 1971

I—ANTIBIOTIC THERAPY; by Pitt and Sewickley Valley Hosp.; Wed. of ea. week. Contact ome Chamovitz, M.D., Sewickley Valley Hosp., Beckburn Rd., Sewickley 15143.

Somerset Community Hospital; October 14, 1970—May 12, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; second Wed. e mo. except Jan. & Feb.; 18 hrs. AAGP credit plied for; $25 fee ($5 single session). Contact CS, Pennsylvania Medical Society, 20 Erford Rd. Lemoyne 17043.

Somerset Community Hospital; Fourth Tues. of ea. m

I—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Western Pa. RP and the Regional PG Medical Faculty Project o ee Hospital, Johnstown; 2 hrs. ea. day; 24 hrs. AAP credit requested ea. year. Contact William WAyres, M.D., Pathologist, Somerset Community Hosp., 225 S. Center Ave., Somerset 15501.

Tunkhannock; March 17—May 19, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program) by Educational and Scientific Trust of PMS; at Tyler Memorial Hospital; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Uniontown Hospital; October 14, 1970—March 24, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; every other Wed., (except December); 30 AAGP credit applied for. $35 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wellsboro; March 17—May 19, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Soldiers & Sailors Hosp.; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wilkes-Barre; March 31—May 26, 1971

I/AMA—CONTINUING EDUCATION COURSE; by Hahnemann; at Wyoming Valley Hosp.; Wednesday each week. Contact David W. Kistler, M.D., D.M.E., Wyoming Valley Hosp., 149 Dana St., Wilkes-Barre 18702.

Wilkes-Barre General Hospital; September 17, 1970—April 15, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; third Thurs. ea. mo.; 8 mos.; 3 hrs. AAGP credit approved for ea. session. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Williamsport Hosp.; September 11, 1970—March 12, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; second Fri. ea. mo. (except January); AAGP credit requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

HEMATOLOGY

Pittsburgh; May 23, 1971—June 6, 1971

I—SEMINARS IN HEMATOLOGY; by Pitt; at Presbyterian-University Hosp.; 3 hrs. ea. day; 2 Sundays; 6 hrs. AAGP credit requested; $25 fee. Contact William M. Cooper, M.D., Dir., Div. of Cont. Edu., Pitt, 1022-G Scaife Hall, Pittsburgh 15213.

INTERNAL MEDICINE

York Hospital; September 17, 1970—April 29, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every Thurs.; 30 weeks; 3 hrs. AAGP credit approved ea. day; $40 fee ($8.00 single session). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Philadelphia; October 14, 1970—May 12, 1971

I/AMA—INTERNAL MEDICINE REVIEWS; by Hahnemann; at Alumni Hall; 3 hrs. a day; 1 day a week; 27 weeks; $150 fee ($70 per subspecialty); 81 hrs. AAGP credit approved. Contact Wilbur A. Oaks, M.D., Prog. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Pittsburgh; September 13—October 15, 1971

I/AMA — INTERNAL MEDICINE REVIEW COURSE; by Pitt and Amer. Coll. of Physicians; at Pitt; 3 hrs. a day; 2 days ea. week; 5 weeks; 33 hrs. AAGP credit requested; $50 fee. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Philadelphia, October 6, 1971—May 31, 1972

I/AMA—INTERNAL MEDICINE REVIEW; at Hahnemann; 3 hrs. ea. day; 1 day ea. week; 33 weeks; 99 hrs. AAGP credit requested; $150 fee for entire course ($50 ea. subspecialty). Contact Mrs. Sage Cordell, Asst. Dir. PG Educ., Hahnemann, 230 North Broad Street, Philadelphia 19102.

MALIGNANT DISEASE

Johnstown; April 18 and May 6, 1971

I—CONTINUING EDUCATION PROGRAM (Cancer Subjects); by Western Pa. RMP; at Sunnehanna Country Club; 2 hrs. ea. day. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

Oil City Hospital; February 11—April 15, 1971

I—CONTINUING EDUCATION PROGRAM (Cancer Subjects); by Western Pa. RMP; second Thurs. ea. mo.; 2 hrs. ea. day. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

Philadelphia; September 9, 1970—June 23, 1971

I—CANCER DETECTION IN OFFICE PRACTICE; at American Oncologic Hosp.; 4 hrs. a day; 1 day a wk.; 20 hrs. AAGP credit approved; course repeated every 5 weeks. Contact Joseph G. Strawitz, M.D., Assoc. Dir., American Orcologic Hosp., Central & Shelmire Aves., Philadelphia 19111.

Sharon General Hospital; February 19—June 18, 1971

I—CLINICAL PROBLEMS IN ONCOLOGY; by Western Pa. RMP; 2 hrs. ea. day; third Fri. ea. mo. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

Warren General Hospital; February 9—June 8, 1971

I—CONTINUING EDUCATION PROGRAM (Cancer Subjects); by Western Pa. RMP; second Tues. ea. mo.; 2 hrs. ea. day. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

Washington Hospital; February 17—May 19, 1971

I—CONTINUING EDUCATION PROGRAM; by Western Pa. RMP; third Wed. ea. mo., 2 hrs. ea. day. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

MICROBIOLOGY & IMMUNOLOGY

Allentown Hosp.; September 10, 1970—June 10, 1971

I—IMMUNOLOGY: BASIC CONCEPTS-CLINICAL APPLICATIONS (A Program of Continuing Medical Education; by Jefferson and Penn State; second Thurs. ea. mo.; 10 mos., 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc., Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

Danville; September 16, 1970—May 19, 1971

I—PSYCHIATRY AND COMMUNITY MENTAL HEALTH; by The Institute of Pennsylvania Hosp.; at Geisinger Medical Center;

2 hrs. ea. day; 1 day a wk.; 10 weeks; 20 hrs. AAGP credit applied for. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Danville; September 24, 1970—May 27, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. per day; 1 day a week; 20 weeks; 40 hrs. AAGP credit applied for $25 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster Gen. Hosp.; February—April, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; 2 hrs. ea. day, 1 day ea. week; 20 weeks ea. semester; 40 hrs. AAGP credit applied for; $25 fee ea. semester. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Norristown State Hospital; March 5, 1971—May 21, 1971

I/S—FAMILY THERAPY; by Norristown State Hospital; 2 hrs. each day; one day each week; 10 weeks; $50 fee. Contact John D. Pruitt, M.D., Dir. Cont. Educ. for Psychiatrists, Norristown State Hospital, Stanbridge and Sterigere Sts., Norristown 19401.

Norristown; March—May, 1971

I—THE LATENCY AGE CHILD: by The Institute of the Pennsylvania Hosp.; at Montgomery Co. Mental Health Clinics, Inc.; 2 hr. a day; 1 day a week; 8 weeks; 16 hrs. AAGP credit applied for; $50 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 21, 1970—June 2, 1971

I/AMA — SEMINARS IN PSYCHOTHERAPY; SHORT-TERM, CRISIS AND SUPPORTIVE THERAPIES; at Hahnemann; three 10-week seminars; every Wed.; 20 hrs. ea. seminar; AAGP credit requested; $75 fee for 10-week session, $150 for 30 sessions. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; April 7—May 12, 1971

I/AMA — DRUGS: PSYCHOTROPIC, PSYCHEDELIC AND ADDICTING; at Hahnemann; every Wed.; 6 weeks; 12 hrs. AAGP credit requested; $50 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; March 24—May 26, 1971

I/AMA — ADOLESCENCE AND THE YOUTH CULTURE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 10 hrs. AAGP credit requested; $75 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CONTINUOUS COURSES

Sessions of the following courses will convene continuously until completed.

ANESTHESIOLOGY

May 27-29, 1971; Pittsburgh

C/LIFE SUPPORT-MAJOR ORGAN SYSTEM FAILURES (Fifth Annual Symposium on Acute Medicine) by Amer. Soc. of Anesthesiologists; at Pittsburgh Hilton; $100 fee. Contact Bulent Kirimli, M.D., c/o Dept. of Anesthes., V.A. Hosp., Pittsburgh 15240.

CARDIOVASCULAR DISEASE

May 6—7, 1971; Pittsburgh

C—EXPLORING SURGICAL TREATMENT FOR MYOCARDIAL INFARCTION; by Pa. Heart Assoc. (21st Annual Scientific Sessions); at Chatham Center; $25 fee (medical students, residents and interns free); $5 additional for ea. luncheon. Deadline for advance registration: April 22. Contact Pa. Heart Assoc., P.O. Box 2435, Harrisburg 17105.

July 19—21, 1971; Philadelphia

C/AMA—BEDSIDE DIAGNOSIS OF HEART DISEASE; by Hahnemann; at Marriott Motor Hotel; 7 hrs. ea. day; 21 hrs. AAGP credit requested; $125 fee. Contact Bernard L. Segal, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

September 21—25, 1971; Philadelphia

C/AMA — CARDIAC ARRHYTHMIAS (Pathophysiology, Pharmacology and Treatment); by Hahnemann; at Marriott Motor Hotel; 7 hrs. ea. day; 4½ days; 31 hours. AAGP credit requested; $125 fee. Contact Mrs. Sage Cordell, Asst. Dir., PG Educ., Hahnemann; 230 N. Broad St., Philadelphia 19102.

September 27-28, 1971; Philadelphia

C/AMA—CURRENT TOPICS IN CARDIOPULMONARY DISEASE-1971: Evolving Concepts in Coronary Artery Disease; by American College of Cardiology; at Temple. Contact Miss Mary Anne McInerny, Dir., Dept. of Cont. Educ., American College of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014.

CHEST DISEASES

April 28—30, 1971; Philadelphia

C/AMA—RESPIRATORY INTENSIVE CARE UNIT; by U. of Pa.; at Annenberg Auditorium (on campus); 7 hrs. ea. day; 21 hrs. AAGP credit requested; $125 fee. Contact Office of Grad. Med. Educ., 288 Med. Labs. Bldg., Philadelphia 19104.

November 1—12, 1971 (February 28—March 10, 1971); Philadelphia

C/PG — TEMPLE UNIVERSITY POSTGRADUATE COURSES IN BRONCHO-ESOPHAGOLOGY; by Drs. Charles M. Norris and Gabriel F. Tucker, Jr. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

ENDOCRINOLOGY

September 1—October 1, 1971; Philadelphia

PG/AMA—ENDOCRINOLOGY (DIABETIC) TUTORIAL COURSE; at Hahnemann; 7 hrs. per day; 20 days; 140 hrs. AAGP credit requested; $100 per week. $350 entire course. Contact Mrs. Sage Cordell, Asst. Dir. Postgraduate Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

FORENSIC MEDICINE

April 14, 1971; William Penn Hotel, Pittsburgh

O—MALPRACTICE IN THE EMERGENCY ROOM; by CES; 3 hrs. AAGP credit $5 fee. Contact Comm. on Emerg. Med. Serv., Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pa. 17043.

GENERAL MEDICINE

December 13—17, 1971; Philadelphia

C/AMA—HIGH BLOOD PRESSURE-1971; by Hahnemann; at Sheraton Hotel; 8 hrs. ea. day; 4½ days; 35 hrs. AAGP credit requested; $125 fee. Contact Mrs. Sage Cordell, Asst. Dir., PG Educ., 230 N. Broad St., Philadelphia 19102.

As Requested, 1971; Philadelphia

PG—ACUTE CARE MEDICINE FELLOWSHIP (retraining program for women physicians); by Woman's; 6 hrs. per day; 1 yr. duration. Contact Ethel Weinberg, M.D., Assoc. Dean, Woman's, 3300 Henry Ave., Philadelphia 19129.

HEMATOLOGY

April 5—30, 1971; Philadelphia (repeat beginning June 7, 1971 and October 4, 1971)

C/PG/AMA — HEMATOLOGY & MEDICAL ONCOLOGY TUTORIAL COURSE; by Hahnemann; 7 hrs. ea. day; 5 days ea. week; 4 weeks; $350 fee ($100 per week). Contact Mrs. Sage Cordell, Asst. Dir., PG Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

INTERNAL MEDICINE

May 19—21, 1971; Philadelphia

C/AMA—PATHOPHYSIOLOGY OF PULMONARY DISEASE; by U. of Pa.; at Annenberg Center of Communications; 7 hrs. ea. day; 21 hrs. AAGP credit requested; $125 fee. Contact Office of Grad. Med. Educ., U. of Pa., 283 Med. Labs. Bldg., Philadelphia 19104.

May 3—14, 1971; Philadelphia (repeat October 4—15, 1971)

C/PG/AMA—EMERGENCY ROOM TUTORIAL COURSE; by Hahnemann; 7 hrs. ea. day; 10½ days; 70 hrs. AAGP credit requested; $400 fee includes daily lunches. Contact Mrs. Sage Cordell, Asst. Dir. PG Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

NEPHROLOGY

April 28, 1971; Kingston

C — INSTITUTE ON RENAL DIALYSIS; by Pa. Dept. of Health; at Mount Airy Lodge; 5 hrs. Contact Miss Mary M. O'Donnell, Regional Office II, 383 Wyoming Ave., Kingston 18704.

June 7—9, 1971; Philadelphia (to be repeated June, 1972)

C/AMA—NEPHROLOGY FOR THE PRACTICING PHYSICIAN; by Hahnemann; at Holiday Inn; 7 hrs. ea. day; 3 days; 21 hrs. AAGP credit requested; $125 fee. Contact Mrs. Sage Cordell, Asst. Dir. PG Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

NEUROLOGY

May 26—28, 1971; Philadelphia

C/AMA—NEWER ASPECTS OF NEUROLOGY AND NEUROSURGERY; by U. of Pa.; at Hospital of U. of Pa., 7 hrs. ea. day; 21 hrs. AAGP credit requested; $100 fee. Contact Office of Grad. Med. Educ., 288 Med. Labs. Bldg., Philadelphia 19104.

OBSTETRICS & GYNECOLOGY

April 15, 1971; Hershey Motor Lodge

C—12TH ANNUAL MATERNAL & CHILD HEALTH INSTITUTE; by CES and Pa. Dept. of Health; $10 fee; 4 hrs. AAGP credit applied for. Contact Comm. on Maternal & Child Health, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

OPHTHALMOLOGY

April 28—30, 1971; Pittsburgh

C/S—OPHTHALMOLOGIC MICRO-SURGERY; by Pitt; at Eye and Ear Hospital; 24 hrs.; $400 fee. 20 limit. Contact Kenneth T. Richardson, M.D. Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

May 5—7, 1971; Pittsburgh

C/S—STRABISMUS (A Comprehensive Symposium in Diagnosis and Treatment); by Pitt; at Eye and Ear Hospital; 24 hrs.; $200 fee; 20 limit. Contact David A. Hiles, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

August 2—6, 1971; Pittsburgh

C/S—THE MANAGEMENT OF RETINAL DETACHMENT; by Pitt.; at Eye & Ear Hosp.; 8 hrs. ea. day; 5 days; $300 fee. Contact William G. Everett, M.D., Dir., Eye & Ear Hosp., 230 Lothrop St., Pittsburgh 15213.

OTOLARYNGOLOGY

April 26—May 7, 1971; Philadelphia

C/AMA—PRACTICAL COURSE IN BRONCHO-ESOPHAGOLOGY; by U. of Pa.; at Grad. Hosp. of U. of Pa., 7 hrs. ea. day; 70 hrs. AAGP credit requested; $250 fee. Contact Office of Grad. Med. Educ., U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

OPHTHALMOLOGY & OTOLARYNGOLOGY

May 19—22, 1971; Bedford

C—1971 SCIENTIFIC MEETING OF PA. ACAD. OF OPHTHALMOLOGY AND OTOLARYNGOLOGY; at Bedford Springs Hotel; $35 fee for non-members; all physicians welcome. Contact Joseph A. Cipcic, M.D., (Secy. Pa. Acad. of O & O), 1501 Locust St., Pittsburgh 15219.

PEDIATRICS

May 5—7, 1971; Philadelphia

C/AMA—BRONCHIAL AND ESOPHAGEAL DISEASE IN INFANCY AND CHILDHOOD; by U. of Pa.; at Grad Hosp. U. of Pa.; 21 hrs. AAGP credit requested; $75 fee. Contact Office of Grad. Med. Educ., U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

May 11—14, 1971; Philadelphia

C—TWENTIETH ANNUAL SEMINAR IN PEDIATRICS; by Temple; at St. Christopher's Hosp., for Children; 28 hrs. AAGP credit requested; $100 fee. Contact John B. Bartram, M.D., St. Christopher's Hosp. for Children, 2600 N. Lawrence St., Philadelphia 19133.

PSYCHIATRY

May 1, 1971; Danville

C—THE INTELLECTUALLY RETARDED CHILD; by Geisinger Medical Center; 5 hrs. AAGP credit requested; $3 fee. Contact Ira B. Bensemer, Ed.D., Geisinger Medical Center, Danville 17821.

May 19, 1971; Philadelphia

C—CONTINUING EDUCATION IN PSYCHIATRY (1971 Teachers Conference); by Pa. Steering Com. for Cont. Educ. in Psychiatry. Contact William H. Dentz, Jr., Exec. Dir., Steering Com., 5600 Derry St., Harrisburg 17111.

One Day Symposium

Diseases of the Kidney'

Friday, April 30, 1971

Fitzgerald Division

M.C.M.C.

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The Greater Delaware Valley Regional Medical Program (GDVRMP) and the University City Science Institute, its coordinating agency, have organized a regional kidney procurement program to provide kidneys for transplantation to patients suffering from kidney disease and who live or are being treated in the area served (southeastern Pennsylvania, southern New Jersey and Delaware).

Information on the program or on arrangements for kidney donation can be obtained by calling (215) 382-6888 at any time or by writing University City Science Institute, 3508 Market St., Philadelphia 19104.

Members of the transplant committee of the regional kidney program are: Aaron D. Bannett, M.D., Albert Einstein Medical Center; Clyde F. Barker, M.D., Hospital of the University of Pennsylvania; Edward D. Coppola, M.D., Hahnemann Medical College and Hospital; Lee W. Henderson, M.D., Hospital of the University of Pennsylvania; and William C. Ellenbogen, project director, University City Science Institute.

obituaries

○ *Indicates membership in the Pennsylvania Medical Society at time of death.*

Laurie L. Allen, Philadelphia; Northwestern University Medical School, 1914; age 86; died September 7, 1970. No survivors are listed.

Lillian S. Alpers, Merion; University of Toronto Faculty of Medicine, 1925; age 67; died December 29, 1970. She is survived by her husband, Bernard Alpers, M.D., and three sons.

Jessie T. Biddle, Washington; Chicago Homeopathic Medical College, 1896; age 101; died December 24, 1970. Surviving is a daughter.

Otto P. Borger, Philadelphia; age 93; died September 21, 1970. No survivors are listed.

Erwin H. Erney, Philadelphia; Medico-Chirurgical College, 1907; age 89; died January 9, 1971. He is survived by his wife and three daughters.

John C. Flanagan, Lafayette Hills; Georgetown University School of Medicine, 1928; age 66; died January 14, 1971. Survivors include his wife, three daughters and two sons, Joseph C. Flanagan, M.D., and John C. Flanagan, Jr., M.D.

Harold E. Garber, Mt. Holly Springs; University of Iowa College of Medicine, 1925; age 71; died December 24, 1970. His wife, two daughters and a son survive.

Harry Hathaway, Cheltenham; Hahnemann Medical College, 1912; age 81; died September 7, 1970. His wife survives.

William F. Leigh, Pottsville; Jefferson Medical College, 1916; age 80; died January 11, 1971. Surviving are his wife, four sisters and a brother.

Bertram Lewin, Pipersville; Johns Hopkins University School of Medicine, 1920; age 74; died January 8, 1971. He is survived by a son and a daughter.

George W. W. Little, Homestead; Howard University School of Medicine, 1923; age 71; died December 22, 1970. Surviving are his wife and a son, George W. W. Little, III, M.D.

○ **Ottomer E. Raezer,** Philadelphia; University of Pennsylvania School of Medicine, 1936. There are no known survivors.

○ **Henry S. Wagner,** Orwigsburg; Jefferson Medical College, 1943; age 53; died January 14, 1971. He is survived by his wife, two daughters, a son, and two brothers.

○ **Creed F. McFall, Jr.,** Pittsburgh; George Washington University, 1948; age 46; died November 21, 1970. Dr. McFall was medical director of the Westinghouse Electric Corporation Research and Development Center. He was a member of the Royal Society of Health in London, England, and a diplomate of the American Board of Internal Medicine. He is survived by his parents and two brothers.

○ **E. Calvin Moore,** Pittsburgh; University of Texas, Medical Branch, 1947; age 47; died December 30, 1970. He was director of community services at Mayview State Hospital, a diplomate of the American Board of Psychiatry and Neurology, and a fellow of the American Psychiatric Society. He is survived by his wife, two sons, and a daughter.

○ **Thomas E. McMurray,** Madison, Ohio; University of Pittsburgh School of Medicine, 1905; age 88; died December 11, 1970. He practiced general medicine for more than forty years in Wilkinsburg, and was a fellow in the American College of Physicians. Survivors include a son and two brothers.

○ **D. George Bloom,** Johnstown; Jefferson Medical College, 1926; age 69; died December 15, 1970. Dr. Bloom had served as chief of surgery at Mercy Hospital and as chief of gynecology at Memorial Hospital. He was a member of the Johnstown Surgical Society, a fellow of the International and American Colleges of Surgeons, and a member of the PMS Board of Trustees, and was a past president of the Cambria County Medical Society. He is survived by two brothers and sixteen nieces and nephews.

○ **Samuel D. Boucher,** Altoona; University of Pennsylvania School of Medicine; age 82; died December 2, 1970. Dr. Boucher practiced for fifty years in the fields of gastroenterology and proctology. He was a fellow of the International Academy of Proctology and a member of the emeritus staff of Nason Hospital in Roaring Spring. Four daughters survive him.

○ **Albert J. Bruecken,** Pittsburgh; University of Pittsburgh, 1913; age 78; died November 23, 1970. He was a hospital pathologist. He is survived by his wife, four sons, one of whom is Albert J. Bruecken, M.D., and a daughter.

○ **Edward H. Drozeski,** Erie; University of Buffalo School of Medicine, 1903; age 90; died November 26, 1970. He served on the staff of Hamot Hospital, and was a selective service examiner. One brother survives.

○ **Carl B. Eshelman,** Shillington; Jefferson Medical College, 1934; age 61; died August 29, 1970. He was a member of the American Board of Orthopedic Surgeons and was an associate in orthopedic surgery at Reading Hospital at the time of his death. No survivors are known.

John L. Johnson, West Chester; Hahnemann Medical School, 1925; age 74; died October 27, 1970. Dr. Johnson was a general practitioner. There are no known survivors.

○ **Harry P. Metzger,** Philadelphia; Hahnemann Medical College, 1916; died during 1970. Prior to his death Dr. Metzger had retired to Fort Myers, Florida. There are no known survivors.

○ **Paul A. Metzger,** Philadelphia; Hahnemann Medical College, 1924; age 70; died November 29, 1970. No survivors are known.

○ **John M. Coe,** Philadelphia; University of Maryland School of Medicine, 1925; age 68; died November 18, 1970. He specialized in industrial medicine and was employed by the Gulf Oil Corporation. Survivors are unknown.

○ **J. Edward Nickel,** Erie; Jefferson Medical College, 1903; age 92; died November 21, 1970. He was medical examiner for the railroad, belonging to the Association of Railroad Surgeons. He is survived by two daughters and a son.

Leonard B. Ulsh, Newport; University of Pennsylvania Medical School, 1930; age 68; died December 6, 1970. He is survived by his wife, a son and a sister.

David H. Ruben, Washington; John Hopkins University Medical School, 1921; age 77; died December 1, 1970. Dr. Ruben was former chief of staff, chief of surgery, and chief of urology at Washington Hospital. He was also past president of the North Central Section of the American Urological Surgeons and diplomate of the American College of Surgeons and of the American Board of Urology. He is survived by his wife; two sons, Malcolm E., M.D. and Jerold R., M.D., both of Washington; one brother and four sisters.

Herbert E. Heim, Allentown; Cornell University School of Medicine, 1931; age 64; died December 7, 1970. He was a charter member of the Pennsylvania Psychiatric Society, and held the position of clinical director at Allentown State Hospital. His only survivor is his widow.

George Hay, Johnstown; Jefferson Medical College, 1903; age 90; died December 8, 1970. He was a member of the Cambria County Medical Society for more than sixty years. He served his county society as treasurer, member of the board, and trustee. His wife, a son, and a daughter survive him.

Harold E. Goldberg, McKeesport; Temple University School of Medicine, 1932; age 63; died December 4, 1970. He was a member of the American College of Radiology and the Pittsburgh Roentgen Ray Society. He is survived by his wife, two daughters, and a sister.

Alfred E. Krick, Philadelphia; Hahnemann Medical College, 1923; age 74; died December 5, 1970. He was retired radiologist for the Bell Telephone Company and emeritus clinical professor of Radiology at Hahnemann Medical College and Hospital. He was also a member of the Radiologic Society of Pennsylvania. Survivors include his wife and two sons.

Ray V. Zabarkes, Philadelphia; Woman's Medical College, 1913; age 83; died January 9, 1971. Prior to her retirement in 1964, she served on the staff of the Albert Einstein Medical Center. Her survivors are a sister and a brother.

Philip E. Sirgany, Scranton; George Washington University School of Medicine, 1938; age 58; died January 19, 1971. He was a member of the Academy of General Practice and a former president of the Lackawanna County Cancer Society. He was on the staffs at Scranton State General, Mercy, and Community Medical Center Hospitals. Surviving are his widow, four sisters, and several nieces and nephews.

Spurgeon T. Shue, Spring Grove; Jefferson Medical College, 1931; age 65; died January 15, 1971. A former president of the York County Medical Society, he was a member of the staff at York Hospital and a deputy county coroner. Surviving are his wife, two sons, one of whom is William M. Shue, M.D., of York, and a brother.

Ernest L. Rosato, Philadelphia; Hahnemann Medical College, 1928; age 68; died January 16, 1971. He taught at Hahnemann Medical College from 1934 to 1964. He belonged to the American Proctology Society and to the Pennsylvania Society of Colon and Rectal Surgery. No survivors are known.

Jacques H. Mitrani, Berwick; George Washington University of Medicine, 1933; age 66; died January 10, 1971. He was a fellow of the American College of Surgeons and a past president of the Columbia County Medical Society. He is survived by his wife, one sister, and one brother.

Charles B. Korns, Sipesville; Baltimore Medical College, 1909; age 88; died January 11, 1971. He was a past president of the Somerset County Medical Society and served as physician and surgeon for the Pittsburgh Coal Co. He is survived by his wife.

Kelvin A. Kasper, Narberth; Jefferson Medical College, 1926; age 82; died January 10, 1971. He was professor of otolaryngology at Jefferson Medical College and chief of staff at Nazareth Hospital. For 25 years until his retirement in 1970 he had been chief of otolaryngology at Wills Eye Hospital. He is survived by his wife.

John A. Kachmarick, Olyphant; Hahnemann Medical College, 1935; age 62; died January 14, 1971. He is survived by a son, John, Jr., M.D., of Alexandria, Va.

Clarence D. Hummel, Easton; University of Pennsylvania School of Medicine, 1918; age 79; died January 11, 1971. He was medical director of Taylor-Wharton Iron and Steel Company and the Treadwell Corporation before his retirement in 1970. Survivors include three sons, one of whom is Conrad D., M.D., of Easton, four daughters, and a sister.

William G. Carman, Pittsburgh; University of Pittsburgh School of Medicine, 1930; age 65; died January 6, 1971. He is survived by his wife, a daughter, and a son.

Guy H. Barnd, Williamstown; Jefferson Medical College, 1923; age 77; died January 1, 1971. His wife and a son survive him.

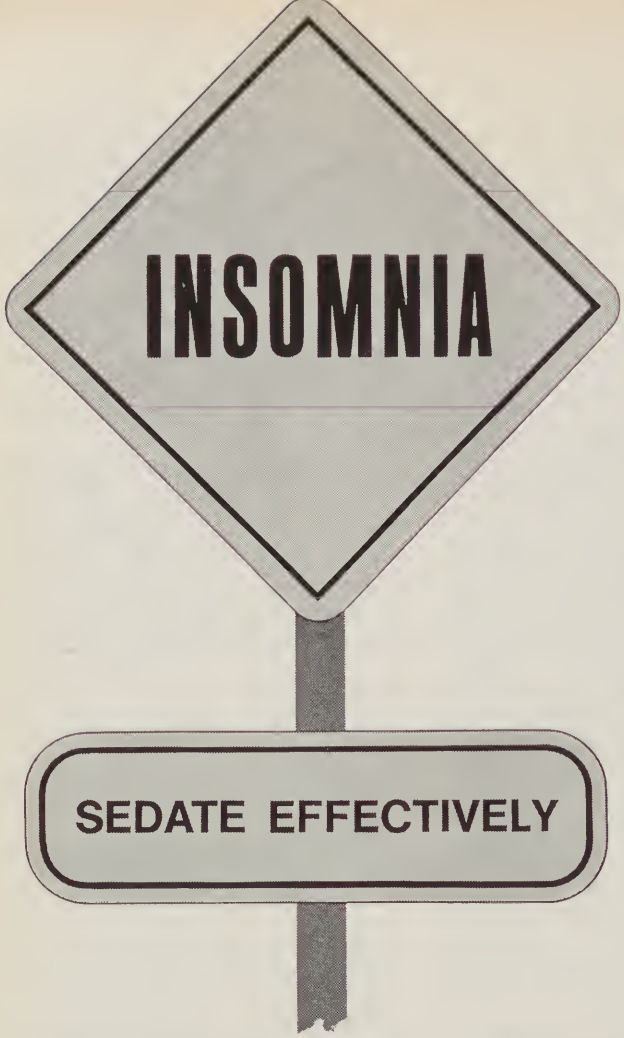
Edgar L. Sowden, Slatedale; Jefferson Medical College, 1911; age 84; died December 12, 1970. No survivors are known.

Frederic M. McPhedran, Philadelphia; University of Toronto, 1912; age 82; died November 29, 1970. Dr. McPhedran was a member of the American Thoracic Society. He was a member of the faculty at University of Pennsylvania School of Medicine, and also on the staff of Children's Hospital and St. Christopher's Hospital for Children. He is survived by his wife, two daughters, two sons, and a sister.

Joseph Margolis-Gordon, Philadelphia; Deutsche University, Czechoslovakia, 1929; age 71; died November 11, 1970. A native of Lithuania, he worked in geriatrics at Kensington, St. Luke's, and Albert Einstein Hospitals.

Herbert M. Stauffer, Philadelphia; Temple University Hospital, 1939; age 56; died December 18, 1970. Dr. Stauffer was special consultant to the U.S. Public Health Service, chairman of the department of radiology at Temple University Medical Center, a fellow of the American College of Radiology, and president of the Association of University Radiologists.

John H. Mentzer, Harrisburg; University of Pennsylvania School of Medicine, 1930; age 67; died December 23, 1970. He was assistant superintendent at the Harrisburg State Hospital, a member of the American Psychiatric Association, and of the American Geriatric Society. He is survived by his wife, three sons, and a sister.



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Robert G. Deichert, M.D., General Hospital, E. Stroudsburg 18301.

MONTGOMERY COUNTY:

Howard J. Marsh, M.D., 3224 Kennedy Rd., Norristown 19401.

PHILADELPHIA COUNTY:

Udon Suvansri, M.D., 2737 Cranston St., Philadelphia 19131.

Arthur B. Tarrow, M.D., 1025 Walnut St., Philadelphia 19107.

Ernest M. Tassoni, M.D., 670 Heatherwood Rd., Rosemont 19010.

J. W. Yarbro, M.D., American Oncological Hospital, Philadelphia 19111.

WARREN COUNTY:

Loreto D. Palma, M.D., 18 Woodcrest Dr., Warren 16365.

Michael P. Ratterman, M.D., 1284 Conewango Ave., Warren 16365.

WASHINGTON COUNTY:

Elpidio D. Damazo, M.D., Old P.O. Building, Avella 15312.

Natividad S. Damazo, M.D., Old P.O. Building, Avella 15312.

WESTMORELAND COUNTY:

H. King Hartman, M.D., 516 Pellis Rd., Greensburg 15601.

Abolhassan Pourhamidi, M.D., Medical Building, Jeff. Ave., Jeannette 15644.

Joe D. Waissman, M.D., 600 Jefferson Ave., Jeannette 15644.

Walter J. Myslewski, M.D., 101 Morewood St., Mt. Pleasant 15666.

YORK COUNTY:

Jose A. Gelpi, M.D., 501 A. Grantley Rd., York 17404.

Janne R. Olson, M.D., Fulton Ave., Stewartstown 17363.

John Mathai, M.D., 1776 S. Queen St., York 17403.

Gary W. Ardison, M.D., 117 W. Main St., Dallastown 17313.

Russel H. Etter, M.D., 924 H. Colonial Ave., York 17403.

meetings

APRIL

Annual spring session of the American Academy of Pediatrics, **April 19-21, 1971,** Chase Park Plaza Hotel, St. Louis, Mo.

PMS Women's Auxiliary Mid-Year Conference, **April 21-22, 1971,** Holiday Inn Town, Harrisburg.

Annual Scientific Meeting of the American Geriatrics Society, **April 23-24, 1971,** Ambassador Hotel, Chicago, Ill.

Annual AMA Congress on Environmental Health, **April 26-27, 1971,** Essex House, New York City. For further information: Write the Department of Environmental, Public, and Occupational Health, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

1971 PMS Officers' Conference, **April 28-29, 1971,** Penn-Harris Motor Inn, Harrisburg.

Annual Pennsylvania Dietetic Association Convention, **April 29-May 1, 1971,** Seven Springs Resort, Champion.

MAY

Annual Clinical Meeting of The American College of Obstetricians and Gynecologists, **May 3-6, 1971,** San Francisco, Cal. Contact: Donald F. Richardson, 79 West Monroe Street, Chicago, Ill. 60603.

Annual Meeting of the Wainwright Tumor Clinic Association, **May 11, 1971,** Polyclinic Hospital, Harrisburg. Contact: Pennsylvania Division, Inc., American Cancer Society, Box 4175, Harrisburg 17111.

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Emergency room physician. Must have Pennsylvania license. Contact Administrator, Aliquippa Hospital, Aliquippa, Pa. 15001. Phone 412-378-8511.

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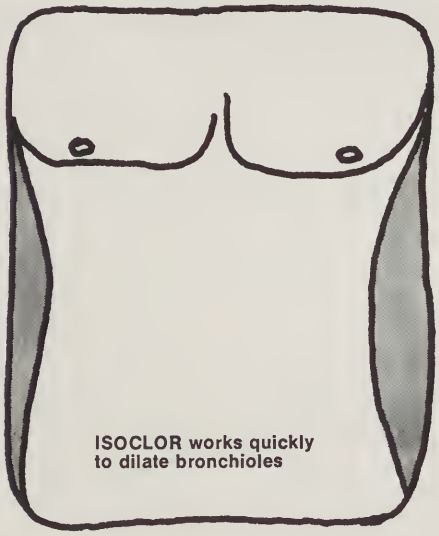

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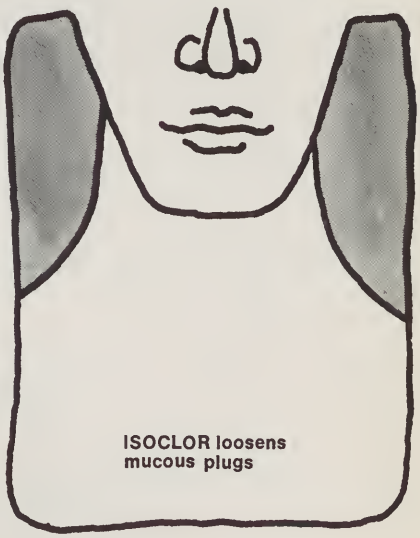

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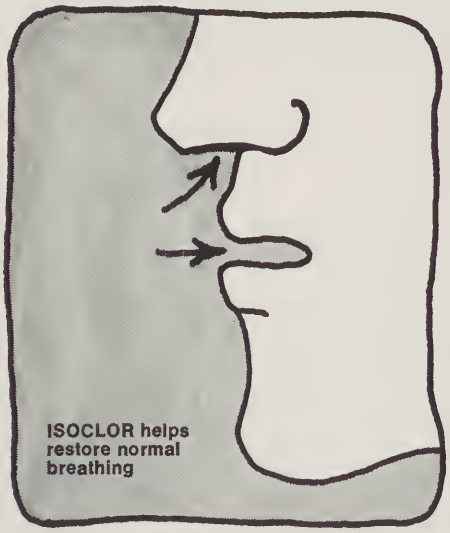

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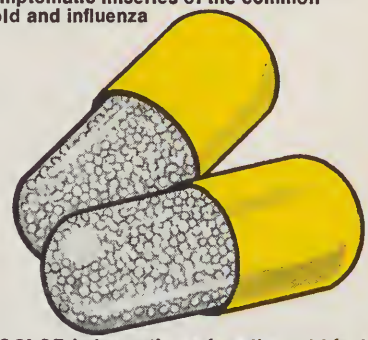

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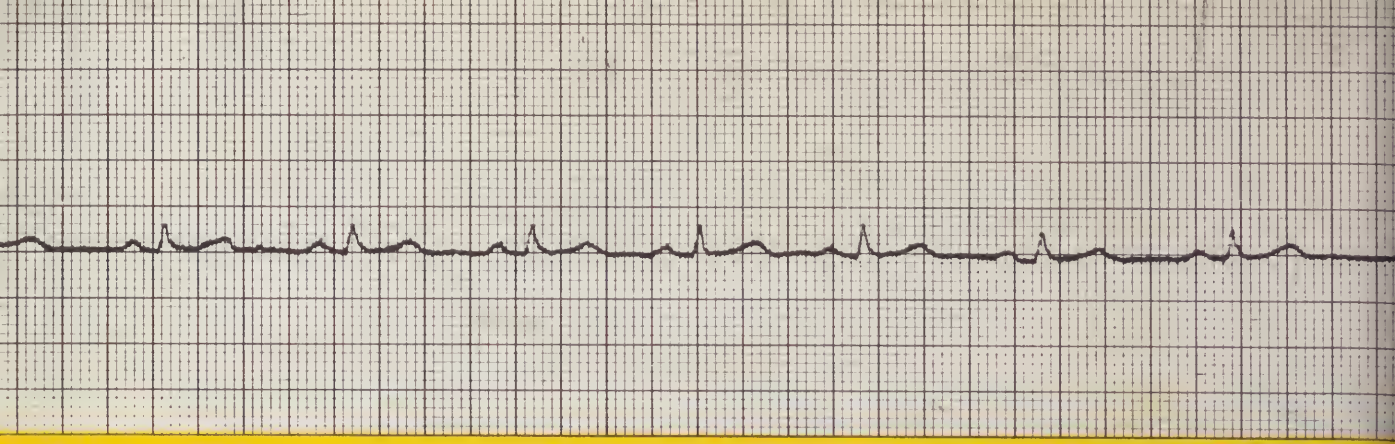

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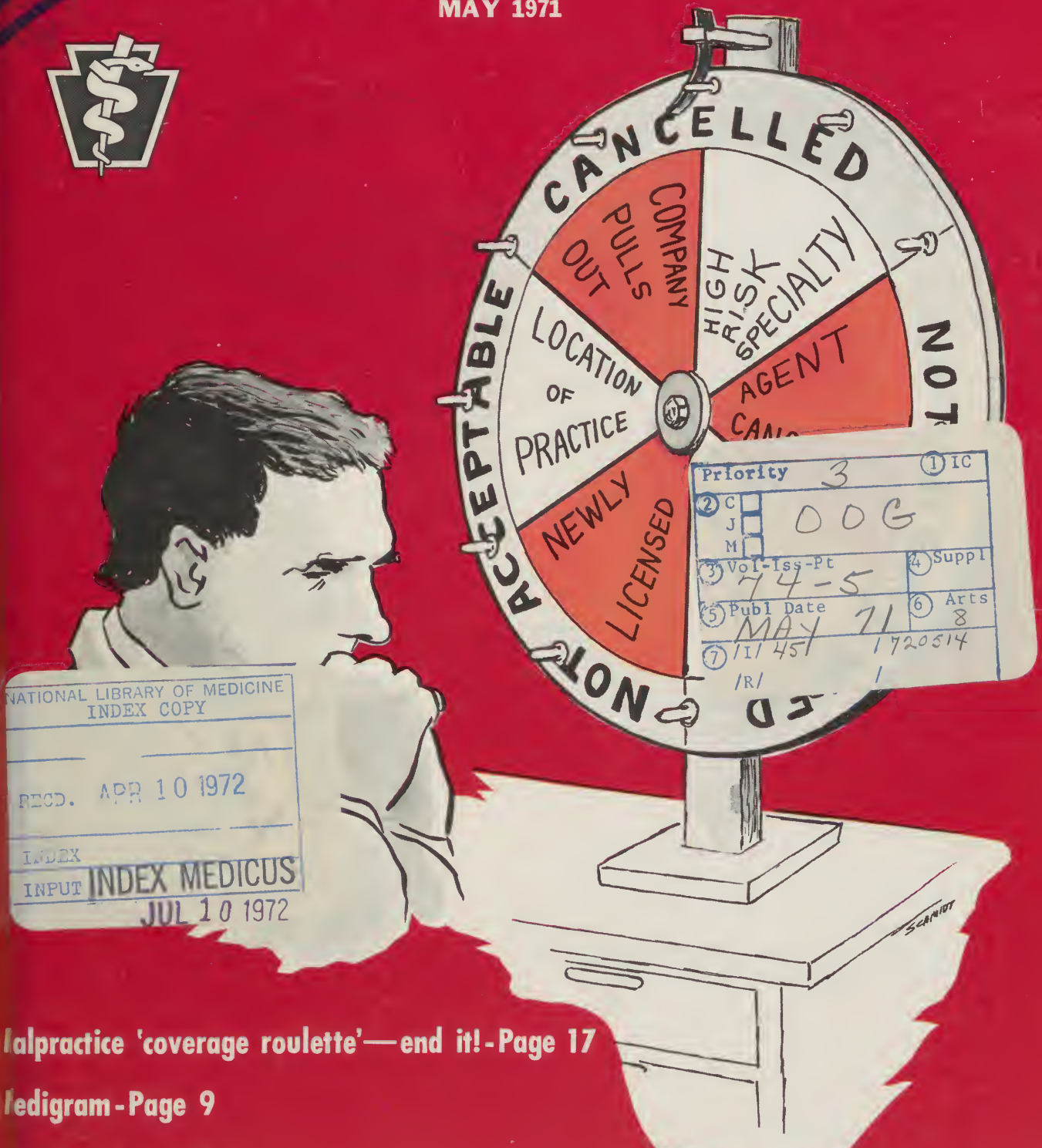

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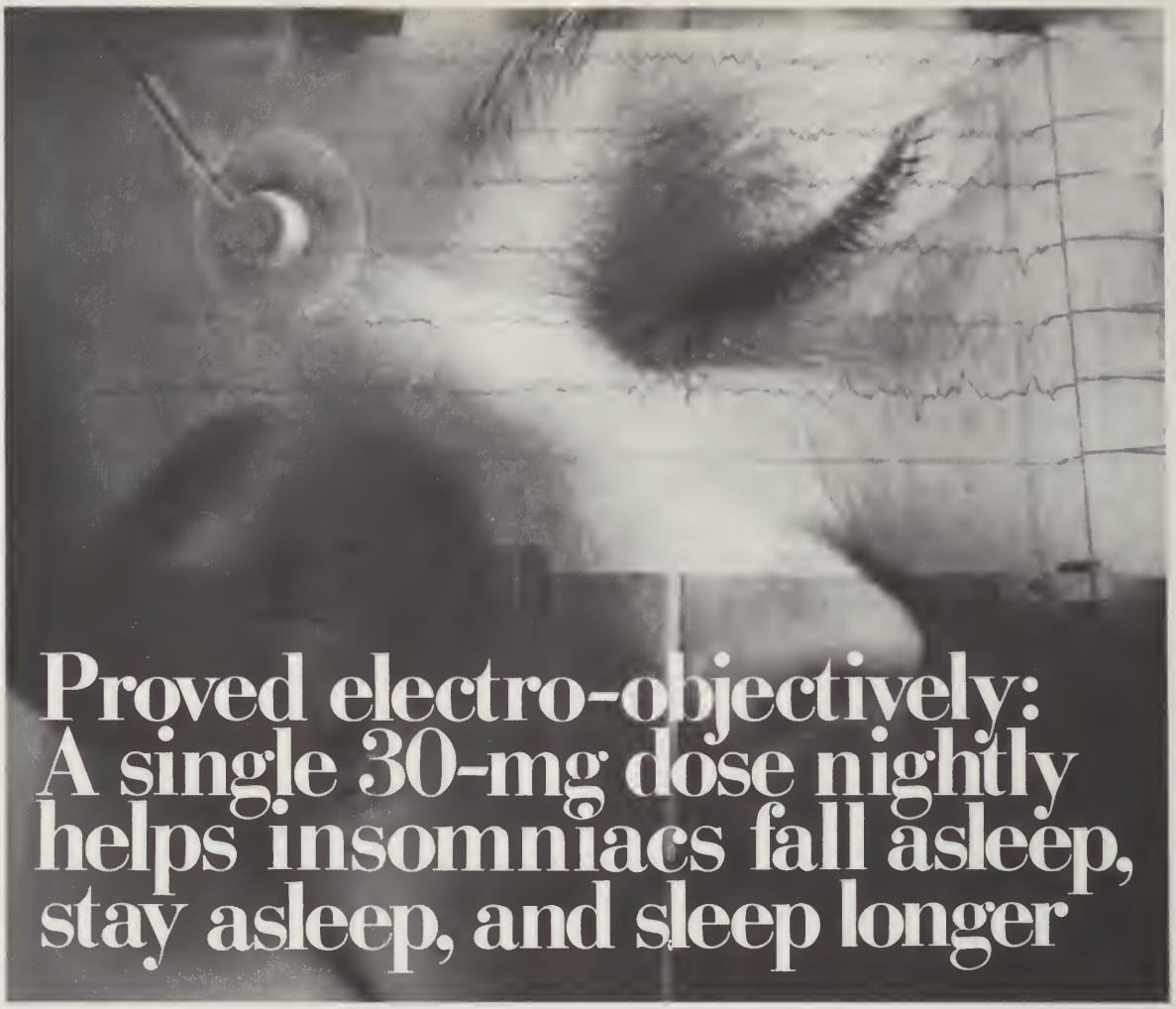

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Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

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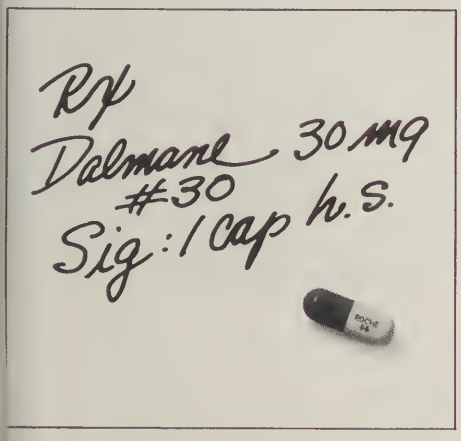
In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.[3] Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

References: 1. Kales, A., *et al.*: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. **2.** Kales, A., *et al.*: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed.): *Sleep: Physiology and Pathology,* Phila., Lippincott, 1969, p. 331. **3.** Data on file, Medical Department, Hoffmann-La Roche Inc.



For the sleep your patients need

New **Dalmane®**
(flurazepam hydrochloride)

Before prescribing, please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.,* excitement, stimulation and hyperactivity, have also been reported in rare instances.

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PENNSYLVANIA MEDICINE

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Journal of the Pennsylvania Medical Society

MAY 1971 VOLUME 74, NUMBER 5

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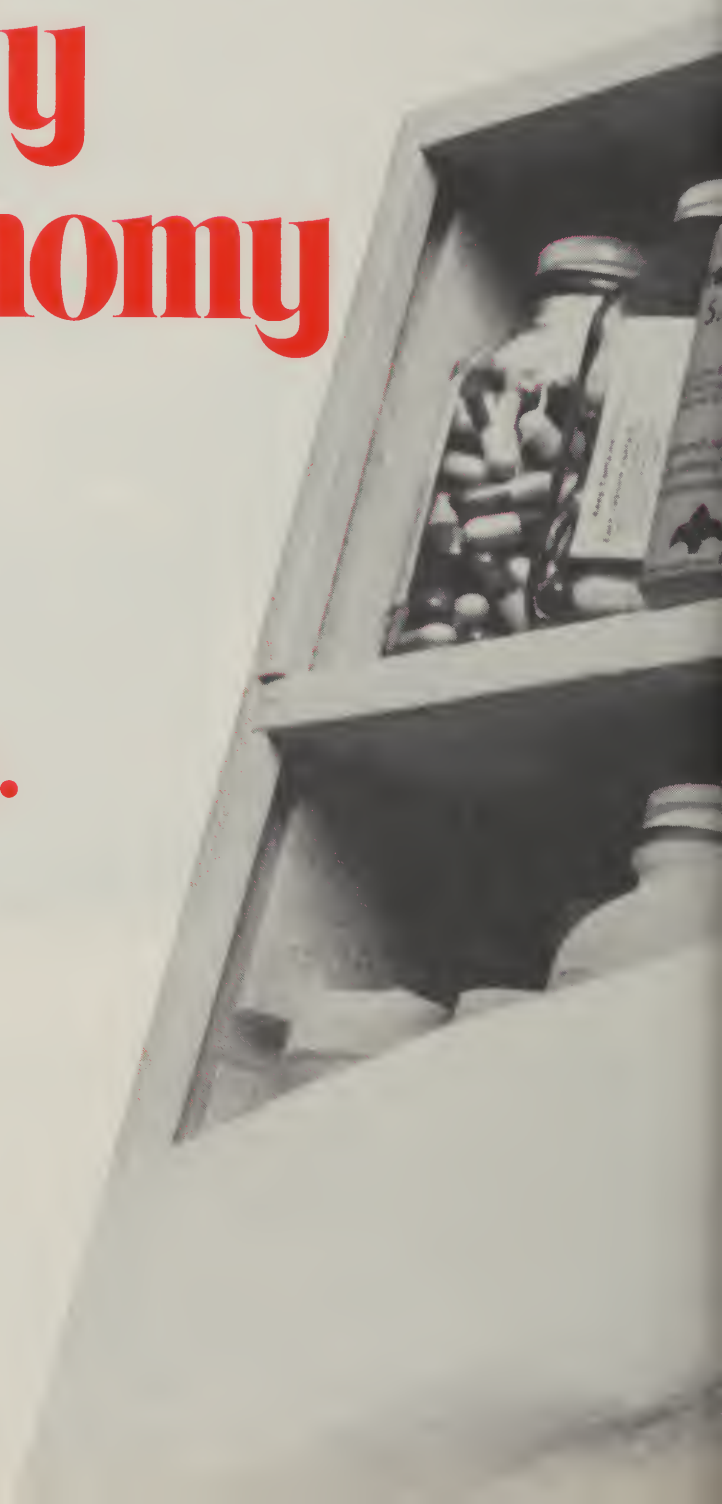

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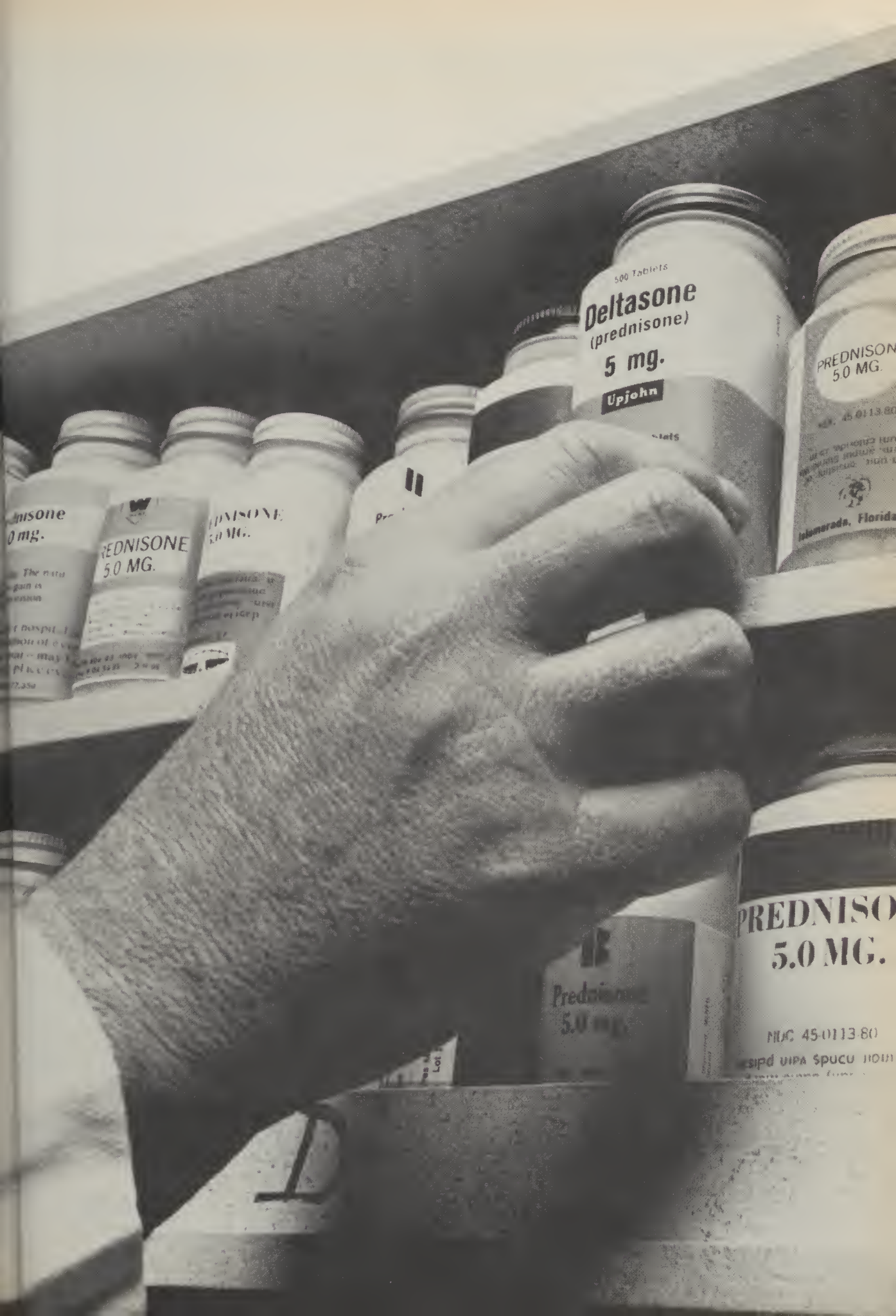
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Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. *Important:* Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptomatically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9-alpha-fluro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoids during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis, an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and, whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angiitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

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For additional product information, consult the package insert or see your Upjohn representative.

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one capsule for the rest of the night

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CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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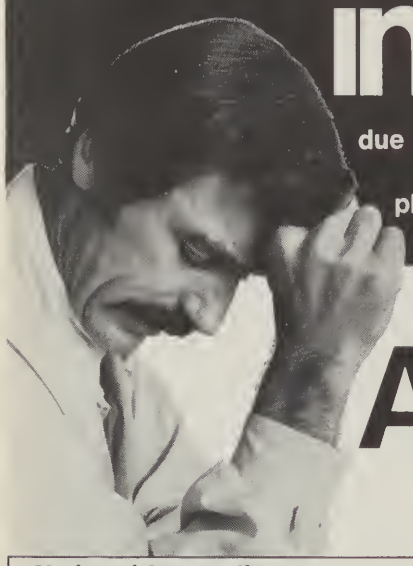

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Fertility and Sterility, January 1970
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Glutamic Acid .....50 mg.	Glutamic Acid .....50 mg.	Glutamic Acid .....50 mg.	Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....10 mg.	Thiamine HCL .....10 mg.	Thiamine HCL .....10 mg.	Thiamine HCL .....25 mg.
Dose: 1 tablet 3 times daily.	*Dose:* 1 tablet 3 times daily.	*Dose:* 1 or 2 tablets daily.	Glutamic Acid .....100 mg.
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Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorena disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasiona cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testo terone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive hear failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prio to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patient receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinue as soon as hypercalcemia is detected.

References: 1. **Monteseno, P., and Evengeliste, I.** Methyltestosterone-thyroid treatment of sexu impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosteror thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impoten Gen Prac 25:6, 1962 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:9 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenes J Urol 79:863. 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Phi delphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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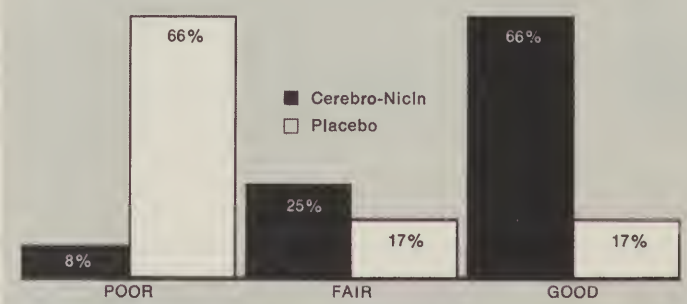

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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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RADIO, TV AWARDS GIVEN AT OFFICERS' CONFERENCE

The PMS Walter F. Donaldson Awards for outstanding programming of news of medical interest were presented at the Society's 1971 Officers' Conference. In television, WFIL-TV Philadelphia, which received the award last year, repeated its winning ways with a program on rehabilitation of alcoholics called "Eagleville: You Are Not Alone." Among stations in smaller cities, WSBA-TV York received the honor for general excellence in reporting of medical affairs. Honorable mention went to WQED Pittsburgh for producing "The Turned-On Crisis," a series on drug abuse. In the field of radio broadcasting the winner among large city stations was WDAS Philadelphia, which also won last year, for a station campaign: "Help a Junkie--Bust a Pusher." The station also received a Freedoms Foundation Award for the campaign. WAHT Lebanon, among stations in smaller cities, won the Donaldson prize and a Peabody Award for a weekly fifteen-minute series, "Medical Viewpoint." WSBA York received honorable mention for its campaign against drug abuse, "Rap-Line." The campaign, which was assisted by the PMS Council on Public Service, was featured in the January issue of PENNSYLVANIA MEDICINE. Newspaper category winners will be announced later.

HEALTH TASK FORCE SCHEDULES HEARINGS

Governor Milton J. Shapp's Task Force on Health Care Delivery is scheduling open hearings throughout the state during May and June, Secretary of Health J. Finton Speller, M.D., has announced. Besides Dr. Speller, members of the task force are: Secretary of Welfare Helene Wohlgemuth, Secretary of Community Affairs William H. Wilcox, Insurance Commissioner Herbert S. Denenberg, and Richard Doran, special assistant to the governor. Dr. Speller said individuals and groups from throughout the Commonwealth will be invited to participate. It is expected that the first hearings will be in Philadelphia late in May, with subsequent sessions in Pittsburgh and Harrisburg.

OVER 200 ATTEND OFFICERS' CONFERENCE

The 1971 Officers' Conference of the Pennsylvania Medical Society last week drew over 200 county society officers from throughout the state to the two-day session which featured discussions of the proposed continuing education requirements for Society membership, the national health care situation, the Pennsylvania Medical Care Foundation, and peer review. U.S. Representative Daniel J. Flood of Pennsylvania's Eleventh Congressional District, chairman of the Subcommittee on Labor, Health, Education and Welfare of the House Appropriations Committee, spoke at the dinner. PMS President William A. Limberger, M.D., gave the keynote address. Details will appear in the June issue of PENNSYLVANIA MEDICINE.

NEW LAWS MAKE NEWS On May 1, 1971 withholding of Pennsylvania's first personal income tax begins. Any person or organization required to withhold tax on wages for Federal income tax purposes must withhold state tax. The 3.5 percent tax, because it is retroactive to January 1, 1971, will be withheld for the balance of this year at a rate of 5.25 percent. Employers are to use Federal Employer Identification numbers and are to determine tax to be withheld in accordance with the approved Withholding Tax Tables available from the state Department of Revenue. Remittance and deposit statements should be mailed to: Commonwealth of Pennsylvania, P.O. Box 3799, Harrisburg, Pa. 17129. Further information is available from the Personal Income Tax Bureau, Pennsylvania Department of Revenue, Harrisburg, Pa. 17127...The Federal Occupational Health and Safety Act became effective April 28. It was the subject of a combined meeting of the Industrial Medical Association and the Association of Industrial Nurses just prior to that date. Joseph J. Schwerha, M.D., chairman of the PMS Commission on Environmental Health, will report on the law in a future issue of PENNSYLVANIA MEDICINE...In this issue, a report of the physician's responsibility under the Controlled Substances Act of 1970, which replaces the Federal Narcotic Act and is effective May 1, 1971, is given. See page 45.

FURTHER HILL HAPPENINGS A PMS-supported bill exempting physicians and nurses from ordinary liability when participating in a mass immunization project has been introduced in the General Assembly as Senate Bill 447. The immunization programs covered would be those sanctioned by the Pennsylvania Department of Health...The Society also is supporting Senate Bill 265, reported previously, which exempts physicians and hospitals from liability for emergency operations and treatment to minors when parents cannot be reached. The latter measure has been reported out of the Judiciary Committee and is before the Senate for action...Dr. Speller has announced that the State Renal Advisory Committee is working for May initiation of patient services under Act 140, Pennsylvania's maintenance hemodialysis program for persons suffering from chronic renal disease. To date thirteen medical institutions have requested participation in the program, Dr. Speller said.

EMERGENCY CARE TOPIC OF MEETING A national symposium to develop an emergency medical services plan to serve as a model for the nation's metropolitan areas will be held May 6 and 7 in Philadelphia. John M. Howard, M.D., professor of surgery at Hahnemann Medical College and Hospital, is chairman of the program committee...The June issue of PENNSYLVANIA MEDICINE will carry a report of the PMS Commission on Emergency Medical Services called "Emergency Medical and Health Services in Pennsylvania."

AMA SESSION IN JUNE The annual session of the American Medical Association, with meetings of its House of Delegates and concurrent scientific programs and exhibits, will be held in Atlantic City the week of June 20. The PMS delegation will introduce a resolution calling for the establishment of national standards for eyeglass lenses and frames, including sunglasses. The resolution would seek the use of safety glass and frames that would not burn to reduce the number of eye injuries.

SPECIAL PART 1 OF APPLICATION FOR LIFE INSURANCE

1. PROPOSED INSURED *(Print full name)* | SEX | Single ( ) Widowed ( ) Married ( ) Separated ( ) Divorced ( )

2. BENEFICIARY *Name and Relationship*

3. DATE OF BIRTH Month Day Year | AGE NEAREST BIRTHDAY | PLACE OF BIRTH | CITIZEN OF

4. AMOUNT OF INSURANCE $

5. FORM SWT TERM with AIP

IS PREMIUM WAIVER FOR DISABILITY DESIRED? YES [X] NO [ ]

6. PREMIUMS PAYABLE ANNUALLY

7. Will this insurance replace any existing life insurance? If "yes" give details and full name of company.

The right to change the beneficiary is reserved. Unless otherwise indicated, payment due two or more beneficiaries shall be in equal shares and to the survivors or survivor of them.

8. RESIDENCE ADDRESS *(Street and Number)* *(City and Zone)* *(State)*

9. NAME OF EMPLOYER AND ADDRESS *(Employer)* *(Street and Number)* *(City and Zone)* *(State)*

10. Have you flown within 5 years as a pilot, student pilot or crew member on any aircraft, or as a passenger on other than a scheduled airline, or do you expect to make such flights? *(If "yes," give details)*

11. OCCUPATION—*Title or duties*

12. Have you ever been told by a physician or practitioner that you had, or have you been treated by a physician or practitioner for:

a. Arthritis, rheumatism, gout or neuritis; mental or nervous disorder? Yes [ ] No [ ]

b. Asthma, pleurisy, tuberculosis, lung disease, anemia or goiter? Yes [ ] No [ ]

c. Heart trouble, chest pain, angina, heart murmurs or high blood pressure? Yes [ ] No [ ]

d. Cancer, tumors, cysts or growths? Yes [ ] No [ ]

e. Diabetes, or albumin, sugar or pus in urine? Yes [ ] No [ ]

f. Disease or disorder of stomach, intestines, liver, or kidneys? Yes [ ] No [ ]

13. Were you ever a patient in a hospital, clinic or sanitarium for examinations or treatment? Yes [ ] No [ ]

14. Have you had health examinations or medical checkup in the past 5 years? Yes [ ] No [ ]

15. Have you been postponed, rated, or declined for life, accident or sickness insurance in the past 5 years? Yes [ ] No [ ]

16. Do you now have, or have you had in the past 5 years any other sickness or injury not referred to in Question 12? Yes [ ] No [ ]

17. Height in shoes ft.____ in.____ Weight in clothes____ lbs.

18. Please explain all "Yes" answers to questions 12 through 17 above, giving full details below:

Question No.	Illness or Condition	Give Dates From	Give Dates To	Give Full Name and Address of All Physicians or Practitioners Consulted

19. FOR HOME OFFICE INDORSEMENT ONLY

I am presently in full time active practice and not retired for reasons of health.

20. PROPOSED INSURED UNDERSTANDS AND AGREES THAT:

1. Part 1 and Part 2, if required, of this application and any supplements thereto shall form the basis for and be a part of any contract of insurance issued on this application, and that all statements and answers in Part 1 and Part 2, if required, of this application and any supplements thereto are complete and true to the best of his knowledge and belief.
2. No insurance shall take effect until the contract is delivered to Proposed Insured and the first premium paid in full all while the Proposed Insured's health and other conditions relating to insurability remain as described in this application.
3. No agent is authorized to make, alter, or discharge any contract; to waive or change any condition or provision of any contract, application, or receipt; to accept any risk, or to pass upon insurability.
4. Acceptance of any contract issued on this application shall constitute ratification of any corrections, additions, or changes made by the Company and noted in the space provided "For Home Office Indorsement Only," except where written consent is required by law.
5. The Proposed Insured shall be the Applicant and owner of any contract issued on this application.

DATED____ 19____ AT____ *(City or Town, State)*

PROPOSED INSURED____ *(Signature in full)*

WITNESSED BY____

PENNSYLVANIA MEDICAL SOCIETY
ORGANIZED 1848 — CHARTERED 1890 — 1847

$50,000 of TERM LIFE INSURANCE

including waiver of premium and additional indemnity provisions

AGE	ANNUAL PREMIUM
16-29	$ 129.00
30-34	150.00
35-39	188.00
40-44	277.50
45-49	428.50
50-54	680.00
55-59	1061.50

MALACHY WHALEN & CO.
1303 Oliver Building
Pittsburgh, Pa. 15222
Tel. 412-391-4731

THE PLAN

Term Life Insurance to age 70 reducing 25% at age 60, an additional 25% of the original amount at age 65 and terminating at age 70. Rates are calculated on a 5 year step-rate basis. The minimum policy to be purchased is $10,000 through age 44 and $5,000 for ages 45 and over.

The Additional Indemnity Provision provides an additional amount equal to the amount of insurance if death should result from accidental bodily injuries.

The Premium Waiver Disability Provision keeps your insurance in full force and effect without premium payment if you are totally disabled for 6 months or longer and if disability occurs prior to contract anniversary date following age 60. (Issued to those age 55 or under who qualify.)

Eligibility - All members in good standing of the Pennsylvania State Medical Society not over age 59 who are actively engaged full time in the duties of their profession are eligible.

Conversion to a form of permanent cash value life insurance is available any time after issue and through age 60.

You May Apply Without Medical Examination In The Following Amount. (We Reserve The Right To Call For Further Evidence Of Insurability)

AGE	AMOUNT	ANNUAL PREMIUM
Through 29	30,000	81.40
30-34	20,000	66.00
35-39	20,000	81.20
40-44	10,000	63.50
45-49	5,000	51.85
50-54	5,000	77.00
55-59	5,000	115.15

These nonmedical limits would include amounts of insurance in force under all medical association plans in Pa. underwritten by The Travelers. The maximum available with evidence of insurability would be $50,000 under all such plans.

This plan is underwritten by:
THE TRAVELERS INSURANCE COMPANY, Hartford, Connecticut, providing Insurance and Financial Planning for Family and Business.

HOW TO APPLY

1. Complete and sign the short application.
2. Sign the Authorization to Attending Physician.
3. Mail your application and check (**made payable to The Travelers Insurance Company**) to the:

PENNSYLVANIA MEDICAL SOCIETY
TAYLOR BYPASS AND ERFORD ROAD
LEMOYNE, PENNSYLVANIA 17043

AUTHORIZATION TO PHYSICIANS OR PRACTITIONERS, HOSPITALS OR OTHER INSTITUTIONS

You are hereby authorized to give The Travelers Insurance Company any and all information you may have regarding my condition when under observation or treatment by you including the history obtained, findings and diagnosis. Photographic copy of this authorization is to be considered acceptable. This is a personal request from me and your cooperation will be appreciated.

_____ 19 _____

_____
Signature of Proposed Insured

AGENT'S CERTIFICATE

Will this insurance replace any existing Life insurance?
(If "yes," give details, full name of company, and state all other life insurance now in force on the life of the proposed insured.)

Signed _____
Agent or Broker

Date _____

New Health Secretary makes debut

A plea to consolidate health functions once more in the State Health Department and spread public health services more effectively to the local level was the theme of the Commonwealth's new secretary of health at his first public appearance since taking office.

The twofold objective was outlined as prime department policy by J. Finton Speller, M.D., in office for just three weeks.

He spoke at the first Pennsylvania Forum on Comprehensive Health Care, a two-day conference in Harrisburg.

Contending that over the years the programs, facilities, and services of public health have been fragmented and divided among non-health agencies, Dr. Speller said:

"What I'm saying to you today is, let's put *health* back into the health department.' "

Dr. Speller proposed: "The Pennsylvania Department of Health must exert every effort possible to increase the seventy-five cents per capita grant to local health departments if we are to bring the delivery of health services closer to our citizens."

Dr. Speller's theme is one repeatedly stated by the Pennsylvania Medical Society, and detailed in the Society's position paper, "Health Care in Pennsylvania in the 1970's, published in June of 1970 in PENNSYLVANIA MEDICINE. Most recently the plea that all health matters in the Commonwealth be placed under the aegis of the Department of Health was made by the Society's Board of Trustees in a letter to the new administration.

Dr. Speller said, "I am hopeful that we can work out arrangements in harmony and good will for the orderly transfer of these health functions, services, and facilities now primarily in the department of Public Welfare and Labor and Industry:

1. The supervision, standard setting, and licensing of hospitals and nursing homes.

2. The planning and determination of need for medical facilities in the commonwealth under Hill-Harris regulations.

3. The administration of the ten state-operated general hospitals.

4. The responsibility for geriatric programs and institutions.

5. The administration of medical care programs for the indigent.

6. Medical care provided for physical rehabilitation.

7. The determination of pneumoconiosis disability.

8. The school health program, which we believe is not as effective as it could be.

"I might also add that the department is now seeking a way to bring a total state commitment to the drug problem. Enforcement, education, and rehabilitation activities are now splintered among various agencies and the Shapp administration will be moving to correct this fragmentation soon."

Medical assistants meet in Pittsburgh

"Medical Horizons Unlimited," the theme for this year's Pennsylvania Society of the Association of Medical Assistants' (AAMA) convention at Pittsburgh on May 13-16 will encompass extensive career-recruitment and educational improvement ideas.

Dane S. Wert, director of communications for the Pennsylvania Medical Society, will be master of ceremonies for the annual banquet, which will be the occasion for the installation of the new president of the Pennsylvania Society of AAMA, Mrs. Agnes E. Smith, R.N., Wilkes-Barre. Lewis T. Buckman, M.D., past president of the Pennsylvania Medical Society, will install the new officers.

Other subjects for discussion and demonstration are new trends in secretarial procedure, administrative duties of medical assistants, parliamentary procedure, medical records, and accounting and modern methods of bookkeeping.

Hepatitis vaccine developed in N.Y.

A significant breakthrough toward the development of a vaccine against serum hepatitis has been announced by the New York University Medical Center. Saul Krugman, M.D., chairman of the department of pediatrics, working with Joan P. Giles, M.D., research associate professor, and Jack Hammond, M.D., director of the Willowbrook State School, Staten Island, have successfully immunized humans against the disease.

Serum made from the MS-2 viral strain and boiled for one minute destroyed the ability of the substance to infect without destroying its ability to produce antibodies. Studies indicated that active immunization could be induced by two injections, not only affording protection against serum hepatitis, but also producing antibodies. Passive immunity resulted in a study of fifteen susceptible individuals exposed to infectious serum. Five were inoculated with standard Gamma Globulin and ten with a special hepatitis B Gamma Globulin. The standard inoculation did not protect three of the five, but the special serum protected all ten recipients.

The breakthrough in control of the disease came in the late 1960's with the discovery of Australia antigen's role in viral hepatitis by Baruch S. Blumberg, M.D., of the Institute for Cancer Research, Philadelphia, followed by its application against serum hepatitis by Alfred M. Prince, M.D., New York City. Dr. Krugman's latest work, while conducted with a comparatively small number of patients, indicates possible control of the disease within the next few years.

Bloodbankers hear of local research efforts

Over 300 physicians and technologists from throughout Pennsylvania met in Camp Hill in April at the annual meeting of the Pennsylvania Association of Blood Banks (PABB), and heard reports from two Harrisburg hematologists of the part played by a group of area residents in further research into the uses of immune globulin (RhoGAM®, Ortho Diagnostics).

The papers were presented by James F. Crispen, M.D., hematologist and director of the blood bank at Harrisburg Polyclinic Hospital, and Herbert S. Bowman, M.D., who holds the same position at Harrisburg Hospital. The two doctors worked with a group of volunteers, forty-four men with Rh negative blood, and presented their findings following transfusions with Rh positive blood, using especially prepared amounts of immune globulin with twenty-two of the volunteers.

The research proved that a larger dose of immune globulin than now given to Rh negative females to prevent hemolytic disease in infants following the birth of each Rh positive child or following abortion can also prevent accidental sensitization of a patient who receives a transfusion of Rh positive blood. William Pollack, Ph.D. vice-president and director of research for Ortho Research Foundation, directed the six-month study. Dr. Pollack is shown in the photograph here explaining the study to the volunteers who were honored at a reception during the annual meeting.

Richard Eisenberg, M.D., of Erie, PABB president, chaired two-day session.

THE PENNSYLVANIA SOCIETY OF INTERNAL MEDICINE received The Component Society of the Year Award at the Fifteenth Annual Banquet of the American Society of Internal Medicine. William J. Kelly, M.D., Pittsburgh, PSIM president, right, accepted the award from Joseph T. Painter, M.D., ASIM president. The award citation listed specific achievements, such as establishing good relations with other state medical and specialty societies, insurance carriers, and medical faculty and students; evidencing an early and continuing interest in utilization and peer review; and strengthening communications with its members. Other PSIM members present were Drs. David H. Feinberg, Easton; Peter L. Saras, Hazleton; James A. Collins, Danville; Robert Pressman, Philadelphia; and Wendell Gordon, Pittsburgh. William B. Harlan, PSIM executive secretary also attended.

Measles increases in state, nation

The Allegheny County Health Department reported an outbreak of regular 9-day measles among school children in early April. The department stated there were 82 cases in the two-week period ending April 7. This brought the count for the year to 115, which was twice as many as for the entire year of 1970 and over 12 times the count for 1969.

Statistics reported by the U.S. Department of Health, Education, and Welfare the first week in April showed more cases than in any four-week period since 1967 in the country as a whole. An analysis of measles cases for this epidemiologic year (EY) beginning with the calendar week 41 and ending with week 40 of the following year show that the 30,900 cases reported to date represent an increase of 175 percent over the total reported for EY 1969-70 and 360 percent over that for EY 1968-69. Up to April 3 the state of Pennsylvania had reported fewer cases than in the same 1969-70 period.

Allegheny County's records indicate that total cases in 1966 were 2,904, in 1967 the number had dropped to 300. and in 1968 only 20 cases were reported. Virginia E. Washburn, M.D., deputy director for medical services, said that the recent upsurge is primarily among first graders and high-school students who probably missed the county immunization program beginning in December of 1966.

State Benjamin Rush awards winners announced

A carpenter who spends long hours serving as a volunteer first aid instructor, and an organization that has aided people with eye defects for more than forty-three years have been named recipients of the Pennsylvania Medical Society's highest health service award for individuals and groups, Park M. Horton, M.D., New Milford, chairman of the PMS Board of Trustees, has announced.

Gustav W. Schukraft, Fleetwood, Berks County, was chosen to receive the 1971 state individual Benjamin Rush Award for his efforts as a first aid instructor as well as other voluntary health activities.

The Greenville Lions Club, Mercer County, was selected to receive the 1971 state organization Benjamin Rush Award for its outstanding work in aiding the sightless and those with eye defects.

Schukraft has been an active first aid instructor since he was certified by the American Red Cross in 1956. He taught thousands of Berks County residents, ranging from nursing students to Boy Scouts. He was nominated by the Berks County Medical Society.

The 141-member Greenville Lions Club has been aiding the blind and people with other eye defects. It has sponsored eye disease screening programs and has established an area eye bank. It provides funds for dozens of other eye activities on a local and state basis and still finds time to assist other health and youth organizations. It was nominated by the Mercer County Medical Society.

Many county medical societies each year present Rush Awards to recognize outstanding voluntary contributions to health, and the state winners are selected from the county winners. The awards honor the memory of Dr. Benjamin Rush of Philadelphia, medical leader and signer of the Declaration of Independence. Dr. Horton said the awards will be presented at the Pennsylvania Medical Society's annual session in Pittsburgh in October.

Internists plan annual meeting at Bedford

"Social Forces and the Practice of Medicine" will be the theme of the Ninth Annual Meeting of the Pennsylvania Society of Internal Medicine to be held at Bedford Springs Hotel, Bedford Springs, Pa., May 14-16, 1971.

Drs. David H. Feinberg, Easton, and Jerome Chamovitz, Sewickley, co-chairmen of the program committee, are in charge of meeting arrangements. Assisting them is Alexander M. Minno, M.D., Pittsburgh.

Topics to be presented at the meeting will include professional corporations, multiphasic screening in health care and health maintenance organizations.

PSIM President William J. Kelly, M.D., Pittsburgh, will preside at the society's annual banquet.

Philadelphia county society joins study

The Philadelphia County Medical Society will become a member of Group Health Planning of Greater Philadelphia, Inc., a prepaid group practice program.

In making the announcement society President George A. Hahn, M.D., said: "While the Philadelphia County Medical Society has serious reservations about the advantages of prepaid group practice to the patient, we accept the invitation of the Group Health Planning of Greater Philadelphia, Inc. to join the planning phase and to assist in the study. It should be understood that the Philadelphia County Medical Society does not necessarily endorse any plan but it deems it essential that any plan, to be most successful to patients, must merit the support of many categories of health personnel, including physicians."

The decision to join the group was made by the society's board.

HE BENJAMIN RUSH AWARDS COMMITTEE is shown above at a session to choose state winners of the PMS Awards which honor individuals and groups whose volunteer work in the health field is outstanding. Members are, l't to right, Ralph K. Shields, M.D., Bethlehem; LeRoy A. Gehris, M.D., Reading; Cyrus B. Slease, M.D., committee chairman, Kittanning; and William J. Kelly, M.D., Pittsburgh.

Joseph Adlestein, M.D., to leave post with state

Joseph Adlestein, M.D., deputy secretary for mental health and mental retardation in the Department of Public Welfare, will become medical director of the Philadelphia Psychiatric Center, a private institution, on July 1. He will replace Louis C. Alikekes, M.D.

In announcing that the deputy secretary will leave public service, Secretary of Public Welfare Helene Wohlgemuth said, "Dr. Adlestein has made major contributions for the benefit of those suffering mental disabilities.

"I regret that he is leaving state government, but I am pleased that his new association will be with the Philadelphia Psychiatric Center, which for many years has worked closely with the state in the mental health field."

Dr. Adlestein, who has been active in Pennsylvania public health and mental health programs since 1951, left a position as medical director of Friends Hospital, Philadelphia, in 1967, to become head of the mental health program under the Mental Health and Mental Retardation Act of 1966.

In a letter to Secretary Wohlgemuth, he said, "In the past four years I feel our advances have been beyond even my greatest expectations," and declared he is "proud of what our staff has accomplished.

"I have always looked forward to eventually returning, once the Act was implemented, in a sense, to where the action is— the actual point of providing services to people. In view of this long-standing desire on my part and of the progress we have made, the opportunity presented to me at this time is one I do not feel I can refuse."

Noting that the Philadelphia Psychiatric Center is the sponsoring agency of a community mental health center serving a significant portion of Philadelphia, Dr. Adlestein said "I am delighted, that I shall have the opportunity of returning to caring for patients in this very stimulating center and still, at the same time, be very much a part of the public mental health effort in this state.

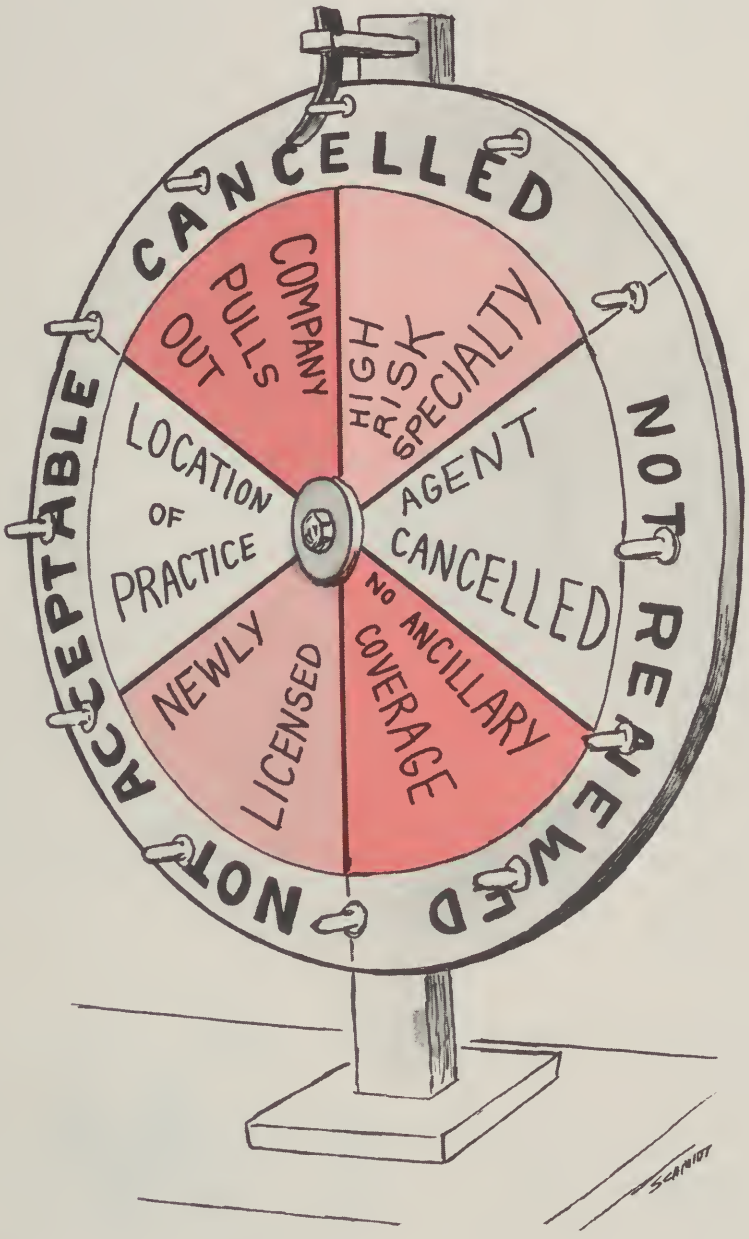
"The community mental health and mental retardation program has made tremendous advances. All counties have been implementing the program during the past two years. All catchment areas of the state now have services within them so that a real network has developed. Future planning can now progress in such a way as to insure services being present in every neighborhood of this Commonwealth rather than in just a few urban areas."

Joseph Gorson, M.D., president of the Philadelphia Psychiatric Center, said he was "especially pleased that the position of medical director, recently vacated by the resignation of Dr. Alikakes, could be filled by bringing a psychiatrist to the institution who is thoroughly familiar with the state and city mental health programs."

"PATIENT NEEDS IN PENNSYLVANIA," subject of a state-wide conference held recently at PMS Headquarters, is discussed, above, by Reno H. Thomas, member of the Pennsylvania House of Representatives from Beavertown, left, with Charles H. Leedham, M.D., Harrisburg, a member of the AMA Committee on Nursing, E. Jean Deeter, director of nursing at Harrisburg Hospital, and Jane Arnold, who has the same position at Harrisburg Polyclinic Hospital. Below is a view of the speakers' table at one of the sessions. Presiding at the conference was Malcolm W. Miller, M.D., Philadelphia, chairman of the PMS Committee on Relationships with Allied Professions. Representatives of organizations in the health professions from throughout the Commonwealth agreed at the meeting to request that the organizations they represent cooperate in establishing and naming representatives to a special group charged with proposing solutions to some of the most pressing health care problems.

Malpractice 'coverage roulette' – end it!

R. ROBERT TYSON, M.D.
Chairman
PMS Commission on Professional Liability Insurance



PMS approved program shows the way

The arbitrary cancellation or non-renewal of a physician's malpractice insurance policy or the unavailability of this vital and necessary coverage to the newly licensed practitioner can be as much of a nightmare as being threatened with a malpractice suit! The incidence of these twin adversities— suits against doctors alleging malpractice and insurance company cancellations, non-renewals and refusals to write malpractice insurance continue to increase throughout the country and the predictions are that this unfortunate state of affairs will get worse before it gets better.

Solution Now Reality

With the complex root causes underlying the increase in malpractice suits continuing to elude the medical, legal and insurance experts, any immediate relief in this area cannot be anticipated.

However, for members of the Pennsylvania Medical Society, a long-range solution to the problem of securing and retaining adequate insurance coverage became a reality on March 17, 1971. The PMS Board of Trustees, acting on a recommendation from the Council on Medical Service, voted unanimously to enter into a five year agreement with the Argonaut Insurance Company as the exclusive carrier, and Parker & Co. Inc. of Pennsylvania as the exclusive administrator and broker of record, to provide professional liability insurance coverage for Society members. The program will become effective June 1, 1971. This unprecedented decision by the Board of Trustees represented the culmination of more than three years of extensive striving by the Council on Medical Service to resolve the mounting insurance availability crisis in Pennsylvania.

One of the council's primary areas of endeavor was the development of a "Model" Professional Liability Insurance Program, subsequent to a survey of our membership made in 1968, which revealed that a majority of those members responding were interested in participating in such a Society sponsored and administered program. Since that time, out of the nineteen insurance companies approached by the Council only the Argonaut Insurance Company demonstrated a sound, sincere interest in underwriting a long-term group program based on the Society's "Model".

Plan Based on "Model"

The Argonaut proposal, as endorsed by the Society, has been specifically designed to make available to all PMS members the best professional liability coverage with adequate limits at the lowest possible cost *and of a long-term nature*! We cannot overemphasize the

tremendous significance of a company formally agreeing to underwrite the Society's membership for a *minimum of five* years during which period it will be bound to uphold the provisions of the individual contracts unless individual cancellation or non-renewal is concurred in by the Society.

Needs Grow Each Year

In Pennsylvania during the past three years, your Society has seen the available market for physicians' professional liability insurance relentlessly diminish while witnessing at the same time the increasingly restrictive and selective underwriting practices of the remaining companies still active in this field. Physicians with no malpractice claims against them have found themselves suddenly without coverage at renewal time as a result of such nebulous reasons as "changes in underwriting eligibility requirements," "agency cancellations" or "unprofitable portfolios". Irrespective of their merit from an insurance industry point of view, such reasons are basically unconscionable to the practicing physician whose responsibility to his patients, his mental well-being, economic security and ability to continue in his profession are all linked inseparably to his being adequately protected at all times by malpractice coverage.

"Coverage Roulette" Avoided

No matter how much longevity an insured physician has built up with his present carrier, or how trouble-free that relationship has been, the fact remains that every twelve months, or perhaps even more frequently, his professional liability coverage is again subject to the whims of his company's underwriter based on the success or misfortunes of the insurance business in general. To the hapless physician, this perennial and involuntary exposure to the vagaries of a situation which at times appears to be analogous to a bout with "coverage roulette" is untenable, and it can become a thing of the past for those members of the Society who choose to be insured by Argonaut under the PMS Program. Once a member's application is accepted he can relax, for at least five years, secure in the knowledge that the

ompany cannot cancel or refuse to enew his policy annually during that eriod without his having the right to ppeal such action to the Society for s review on his behalf.

Society Participation Unique

This five year coverage security fea- re made available by Argonaut ider the PMS-sponsored program *is t being offered by any other carrier iting professional liability insurance Pennsylvania* and represents a sig- ficant "plus" factor which no Society ember can really afford to do thout. Additionally, the PMS Pro- am is unique insofar as it provides the Society's participation on lhalf of its members in those areas of dministration which, although of vital d direct importance to the insured ysician, are generally held by the in- rance industry as being sacrosanct.

For instance, the Program provides f the Society's complete review of all stistical information relative to clas- cation and rate-making purposes, sh as premiums written and earned, iestment income, claims reserves al claims payments and loss figures. lso provides for the Society's exten- se involvement in underwriting disions including its review in all ces where Argonaut has (a) refused toprovide coverage for a member of tl Society, (b) expressed a desire to terminate coverage for a member, or (c) proposed to restrict coverage based on the type of medical specialty of any members. Finally, the program contemplates the Society providing advice to Argonaut on matters related to claims settlements where the insured member and the Argonaut are in disagreement as to whether or not a claim or suit should be settled. It readily can be seen that certain of these activities also lend themselves to the overall peer review concept, increased pressures for which are inevitable from a variety of sources.

To implement this "partnership" role enjoyed by the Society under its agreement with Argonaut, the Board of Trustees has approved the formation of a "Commission on Professional Liability Insurance" which will supervise the Society's responsibilities in the operation and administration of the program, including the formulation of any recommendations for changes or modifications for subsequent consideration of the Council on Medical Service and the Board of Trustees. It is proposed that the new commission, which incidentally has assumed the responsibilities previously assigned to the Council's Subcommittee on Medical Malpractice, since the subcommittee has been dissolved, will be composed of at least twelve members, representing each Councilor District. These members will have some familiarity with the problems of medical malpractice, and will be participants in the program or will join at the expiration of their in-force malpractice coverage. Additionally, the commission will have three ex-officio members consisting of the Society's legal counsel, an Argonaut representative and a representative of Parker & Co., the Program's Administrator.

The Board of Trustees also approved the organization of Professional Liability Insurance Committees on a Councilor District level. They will be responsible for providing advice to Argonaut upon request on matters related to underwriting decisions and claims settlements. These district committees will play an important role in the program insofar as it is anticipated that most problems will be able to be resolved at that level. Unresolved situations will be referred to the Commission on Professional Liability Insurance, to whom the district committees will be responsible, with the commission having final authority in decisions. On the expectation that the new commission will have to meet at least quarterly and perhaps more often during the first year of the program, a modest budget for the antici-

pated expenses of such activity has been approved by the Board of Trustees.

Companies' Records Good

Information on the carrier and the administrator is appropriate. Argonaut is a reliable, well-established general liability insurance carrier with considerable experience in affording medical liability coverage through its involvement at the present time with the underwriting of twenty-two state hospital associations. In addition, the company has recently entered into similar physician association programs with the state medical societies of Hawaii and Idaho. The A.M. Best Company which annually rates companies in the insurance industry, gave Argonaut an "A + AAAA" rating. The company's assets are in excess of $180 million with a policyholders' surplus as of December 31, 1970 of over $33 million. Argonaut has indicated that, if through the efforts of all concerned, the loss experience of PMS members is held to a permissible level, it will consider refunding any savings over losses and expenses in the form of a dividend— subject, of course, to prior consultation with the Society, and with the approval of the Pennsylvania Insurance Department. To this end Argonaut, is pledged to initiate and provide a program of continuous safety and claims prevention education directed to all members insureds and conducted jointly with the Society. The education is aimed at avoiding and preventing the kinds of incidents and accidents that lead to potential malpractice suits.

Parker & Co. Inc. of Pennsylvania, the designated full-time administrator of the Society's Program, is one of the country's leading insurance brokerage firms and already enjoys some previous experience in the administration of a similar state program. Its special Professional Liability Insurance Unit newly formed to administer the PMS Program is headed by Vice-President A. John Smither, who before joining Parker several months ago culminated an insurance career of more than twenty-two years by serving a full term as the Commonwealth's Chief Deputy Insurance Commissioner during the administration of Governor Raymond P. Shafer. As part of his official duties he also served as Chairman of Pennsylvania's Ad Hoc Committee on Medical Malpractice and in that capacity demonstrated a concerned and sympathetic attitude toward the insurance problems faced by the Pennsylvania medical profession at large.

Mr. Smither, upon invitation, is prepared to appear before any county medical society meeting to discuss and answer questions on the PMS Program. The relative proximity of Parker's executive offices in Philadelphia to the Society's headquarters in Harrisburg ensures that a close everyday working relationship between the two organizations can be realized. Additionally, as participation grows, particularly in respect to insured members from the western part of the Commonwealth, Parker is prepared to open a Pittsburgh office to facilitate its continued efficient administration of the program.

Dr. Tyson is a member of the PMS Council on Medical Service and was chairman of the Subcommittee on Medical Malpractice while that group was preparing the program explained in this article. Dr. Tyson also is chairman of the PMS Committee on Constitution and Bylaws, president-elect of the Philadelphia County Medical Society, and alternate delegate to the AMA House of Delegates. He is professor of surgery and chief of the vascular section of the department of surgery at Temple University School of Medicine and Hospital. He serves as consultant in surgery at the Wilkes-Barre and Philadelphia VA Hospitals.

Argonaut will issue individual contracts offering full liability coverage of $100,000 for each claim, subject to annual aggregate limits of $300,000, with excess limits to $1,000,000 available. Each member will be rated individually with rates comparable to and competitive with those followed by the major writers of medical professional liability insurance in Pennsylvania. Coverage for interns and residents as well as for physicians' and surgeons' assistants will also be made available.

Argonaut also is prepared to provide by endorsement to its policy, and subject to a reasonable charge made on an individual basis, so-called "drop-back" coverage for those members enrolling who are presently insured with Lloyds of London under its "claims made" policy.

This, then, is the long-awaited, PMS-sponsored, Professional Liability Insurance Program which had its genesis in the serious problems faced by all too many of our members during the past four years. The "association solution" approach which the Program offers has your Society's enthusiastic approval. For its success to be assured it needs but one additional, vital ingredient— "association support"— support which must be truly broad-based both as to range of medical classifications or specialities and by geographical location of practice. The significant long-term benefits to Pennsylvania's medical fraternity which can emanate from the Program's key features, "five year coverage guarantee," "peer review of rejected member applicants," "peer review of individual member claim or settlement disputes" and full Society involvement in all pertinent aspects of the program's administration, are obvious. Without question the program deserves the support of and warrants participation by the entire membership.

The Society hopes that every member will complete and mail the coupon on the inside back cover of this issue as an indication of their interest in participating in the PMS program effective with the expiration date of their present coverage. Acceptance by Argonaut could mean an end to "coverage roulette" for the individual member and the beginning of an equitable and stable malpractice insurance climate in Pennsylvania. □

Choose the smooth road

to thyroid replacement therapy

The automatic

transition.

Your patients start thyroid therapy smoothly, easily. They feel better all along the way with no metabolic "bumps."

The gradual physiologic action of T_4 SYNTHROID provides virtually an "automatic" transition through the range of complete thyroid replacement therapy.[1]

Predictably responsive!

This kind of comfortable patient response has made SYNTHROID the most widely prescribed brand of thyroid drug in the United States. It's a Cadillac of thyroid medications ... with Volkswagen economy.[2]

The road to normalized thyroid status is a continuous one. You make it smooth and economical with SYNTHROID.

1. The deiodination of T_4 to T_3 at the cellular level has been discussed in the literature. Reprints on the subject are available from the Flint Laboratories Medical Department. Use of T_4 alone therefore provides your patients with a natural hormone combination of T_3—T_4.
2. Patient cost of SYNTHROID is less than a penny a day more than desiccated thyroid. SYNTHROID costs patients nearly 50% *less* than the synthetic combination products: American Druggist BLUEBOOK, March 1970-71

Synthroid®
(sodium levothyroxine)

FREE
MEDICATION DISPENSERS
TO START ALL YOUR PATIENTS ON SYNTHROID, IN THESE STRENGTHS:
0.05 mg. (white); 0.1 mg. (yellow); 0.15 mg. (violet); 0.2 mg. (pink).

seven color-coded strengths plus injectable

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) Tablets include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) Injection is indicated in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. When a patient does not respond to oral therapy, SYNTHROID (sodium levothyroxine) injection may be administered intravenously to avoid any question of poor absorption by either the oral or the intramuscular route.
Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmond's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.
Contraindications: Thyrotoxicosis, acute myocardial infarction.
Side effects: The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.
Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).
Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100 and 500. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) INJECTION may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

FLINT LABORATORIES
DIVISION OF TRAVENOL LABORATORIES, INC.
Morton Grove, Illinois 60053

As your hypothyroid patients travel along the smooth road, let us be of service in these 4 specific ways:

1 FREE FILM AND BOOK ON HYPOTHYROIDISM: In a 30-minute, 16-mm. sound/color film, 5 prominent endocrinologists discuss "Thyroid Deficiency—Current Concepts of Diagnosis and Treatment". Film available on FREE loan to physician groups or hospitals.

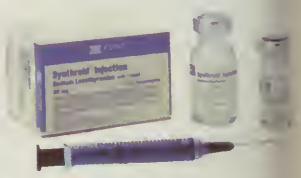
A new book, soon to be published, is devoted to the clinical aspects of hypothyroidism. The author, a leading endocrinologist, describes the many faces of the condition and emphasizes the importance of clinical assessment of the patient. Write, or ask your Flint man, to be placed on our list to receive a free copy.

2 NEW THYROID FUNCTION TEST BOOK: Newly published *Guideposts to Thyroid Therapy* discusses the tests most appropriate for use with each type of thyroid medication. Fully describes thyroid function tests and places their relative values in perspective for physicians. It will give you valuable new insights into the role of these tests in diagnosis and treatment. FREE—ask your Flint man.

3 TO START THERAPY, FREE TAB-MINDER dispensing units, color-coded to match colors of SYNTHROID tablets in starting dosage strengths. TAB-MINDER helps patients to regularly take the thyroid dosage you prescribe, avoid medication errors. Ask your Flint man.

FREE MEDICATION DISPENSERS TO START ALL YOUR PATIENTS ON SYNTHROID, IN THESE STRENGTHS: 0.05 mg. (white); 0.1 mg. (yellow); 0.15 mg. (violet); 0.2 mg. (pink).

4 SYNTHROID® INJECTION FOR THYROID EMERGENCIES: Whenever (as in myxedema coma) rapid replacement of thyroid hormone is needed to sustain life, prompt clinical response is essential. SYNTHROID INJECTION makes this therapy instantly available. Useful also in postoperative thyroid medication situations until oral therapy can be reinstated. Ask your Flint man for further information.



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American physicians are urgently needed, especially general practitioners, general surgeons, internists, ophthalmologists, orthopedic surgeons, pediatricians, and preventive medicine specialists.

For further information please write to:

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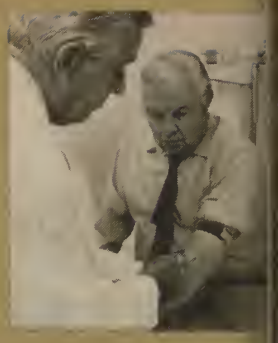
in stable adult diabetes, if diet alone fails...



start with DBI®-TD (phenformin HCl)

timed-disintegration capsules 50 mg.

A Distinctive Oral Hypoglycemic

---

a biguanide... not a sulfonylurea

Lowers elevated blood sugar without increasing endogenous insulin secretion.

Probably, secondary to its hypoglycemic effect, decreases insulin oversecretion. This may help to reduce lipogenesis and facilitate lipolysis, which may account for the clinically reported loss of excess body weight and lowering of elevated serum cholesterol levels in overweight, hypercholesteremic, stable adult diabetics unresponsive to diet alone.

DBI®-TD
(phenformin HCl)
timed-disintegration capsules 50 mg.

lowers elevated blood sugar

How to prescribe DBI®-TD (phenformin HCl)

To start with DBI-TD

Week 1	1 capsule with breakfast may be effective, or a second capsule may be given with the evening meal.
Week 2	Continue effective DBI-TD dosage. If necessary, add an additional capsule to the A.M. or P.M. dose.
Thereafter	Continue effective DBI-TD dosage.

To transfer from sulfonylurea therapy to DBI-TD alone: The first week, withdraw sulfonylurea; start with DBI-TD as indicated in the chart.

To transfer from sulfonylurea therapy to combined therapy with DBI-TD: The first week, continue dosage of sulfonylurea; add DBI-TD as indicated in the chart. When effective regulation of diabetes is attained, sulfonylurea may be reduced and/or withdrawn.

Indications: Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary. **Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes that is uncomplicated and well regulated on insulin; acute complications of diabetes (metabolic acidosis, coma, infection, gangrene); surgery; severe hepatic disease; renal disease with uremia; cardiovascular collapse, after disease states associated with hypoxemia. **Warning:** Use during pregnancy is to be avoided. Until adequate data on the effects of DBI on the human fetus are available, such use can be considered experimental. **Precautions: Starvation Ketosis,** which must be differentiated from "insulin lack" ketosis, and is characterized by ketonuria in spite of relatively normal blood and urine sugar, may result from excessive DBI therapy, excessive insulin reduction or insufficient carbohydrate intake. Adjustment of DBI-TD or insulin dosage, or supplying carbohydrates, alleviates this state. DO NOT GIVE INSULIN WITHOUT FIRST CHECKING BLOOD AND URINE SUGARS. **Lactic Acidosis:** DBI is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, it is recommended that periodic determinations of ketones in the blood and urine be made in diabetics previously stabilized on DBI, or DBI and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH and the lactate-pyruvate ratio. DBI should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis. **Hypoglycemia:** Although hypoglycemic reactions are rare when DBI is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with DBI. **Adverse Reactions:** Principally gastrointestinal, occurring more often at higher dosage levels; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, DBI should be immediately withdrawn. Although rare, urticaria and gastrointestinal symptoms following excessive alcohol intake have been reported. **Dosage:** 1 to 3 DBI-TD 50 mg. capsules daily. **FSN 6505-724-6331. Also Available:** DBI tablets 25 mg. **Supplied:** Bottles of 100 and 1000.

USV PHARMACEUTICAL CORP., Tuckahoe, N.Y. 10707 USV

decision:

Loridine® I.M.
Cephaloridine

1.5 to 3 Gm. daily successfully treats many moderately severe infections*

indicated for use against
susceptible organisms causing:
pneumonia
urinary tract infections
septicemia
abscesses
relatively painless I.M.
injection

due to susceptible organisms

Special Recommendations
Before Administration of Loridine
1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.
During Administration of Loridine
1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

Lilly
100913

Loridine®
CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169]

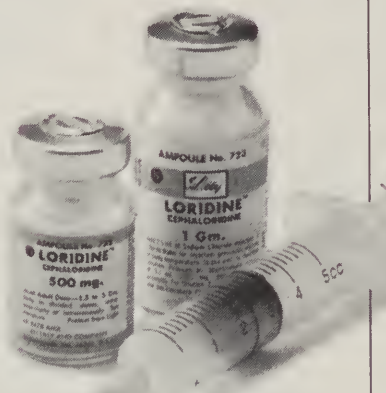
Additional information available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly

000903

Loridine®
CEPHALORIDINE



Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

m.d.'s in the news

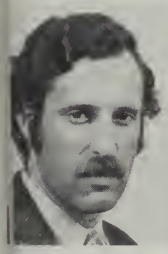
The Lycoming County Medical Society has honored **Howard H. Weaner, M.D.,** as the first member of the new board of family practice, sponsored by the American Academy of General Practice.

Joseph P. Viglione, M.D., of Stroudsburg has received a patent for a "hydrolig," a device containing fluid which, when strapped to an athlete's knee, affords protection against injury. When an impact occurs on any part of the sac, the pressure is equally distributed, lessening the chance of injury.

Recognition for fifty years of service has been given in the form of PMS Fifty-year Awards presented to **Howard G. Lafferty, M.D.,** by the Mercer County Medical Society, and to **Alexander Martin, M.D.,** by the Cambria County Medical Society.

Recently elected presidents of county medical societies in the state include **John E. German, M.D.,** Berks County Medical Society; **Charles Sloan, M.D.,** Fayette County Medical Society; **Donald E. Burkett, M.D.,** Cambria County Medical Society; **George B. Davis, M.D.,** Luzerne County Medical Society; and **A. Reid Leopold, M.D.,** Mifflin-Juniata County Medical Society.

Peter A. Herbut, M.D., president of Thomas Jefferson University, has been elected president of United Health Services, a United Fund agency operating in the Greater Philadelphia area. The agency last year received $32,192 from the United Fund Torch Drive of Philadelphia.



DR. TROBE

DR. HERBUT

Wills Eye Hospital and Research Institute has appointed **Jonathan D. Trobe, M.D.,** Cambridge, Mass., as chief resident surgeon. Dr. Trobe, himself the recipient of a corneal transplantation, will also serve on the faculty.

A new textbook entitled, *Principles and Practice of Spinal Anesthesia*, the first complete work on the subject since 1938, has been written by **Peere C. Lund, M.D.,** Johnstown, head of the department of anesthesiology of the Conemaugh Valley Memorial Hospital. Representing the work of more than twenty years, the textbook is intended primarily for use by anesthesiologists, surgeons, and residents in training for all medical specialties. Dr. Lund is associate clinical professor of anesthesiology at the University of Pittsburgh School of Medicine.

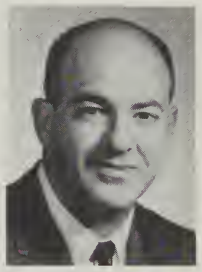
A number of county societies have announced new presidents. In Fayette County, **Charles Sloan, M.D.,** is the new president, with **Arthur Varga, M.D.** taking the position of president-elect. The Mifflin-Juniata County Society reports their new president will be **A. Reid Leopold, M.D. David J. Keck, M.D.,** succeeded retiring president, **Richard Eisenberg, M.D.,** as president of the Erie County Medical Society.

David Myers, M.D., Philadelphia, professor of otolaryngology at the University of Pennsylvania, returned recently from a lecture tour abroad. He addressed the faculties of otolaryngology at the University of Athens, the University of Madrid, and the University of Lisbon.

William Tyler Douglass, Jr., M.D., of Harrisburg was chosen as president-elect of the International Academy of Proctology, the teaching organization of the International Board of Proctology, at the twenty-third annual teaching congress of the academy at Mexico City. He will be inducted as president at the 1972 meeting in San Diego, Calif., and will preside at the congress to be held in Bangkok, Thailand, in 1973.

This position is a special honor for a surgeon in private practice, as it has traditionally been held by a professor of surgery who devotes his full time to teaching. Dr. Douglass is the first American in four years to head the organization.

Cyril H. Wecht, M.D., has been elected president of the American Academy of Forensic Sciences. Dr. Wecht, coroner of Allegheny County, is also director of the Pittsburgh Pathology and Toxicology Laboratory. He is a graduate of the University of Pittsburgh and its schools of medicine and law and is director of the Institute of Forensic Sciences and research professor of law at Duquesne University law school.



DR. WECHT

DR. PLAUT

An interesting new faculty appointment recently announced by **William P. Barba, M.D.,** acting dean of Temple University School of Medicine, is that of **Gerhard W. E. Plaut, M.D.,** who comes from Rutgers Medical School to become professor and chairman of the department of biochemistry. He succeeds **Robert H. Hamilton, M.D.,** who will remain on the faculty as professor of biochemistry. Dr. Plaut holds a Research Career Award from the U.S. Public Health Service from 1962-66 and is a member of the National Board of Medical Examiners. Several of his colleagues are also joining the staff at Temple, including **Drs. Michael C. Scrutton** and **J. Kenneth Hoober,** associate professors, and **Drs. Agnes T. Yip** and **Tadashi Aogaichi,** instructors.

Milton J. Freiwald, M.D., staff physician of the Albert Einstein Medical Center, Philadelphia, recently addressed the faculty and students at the University of the West Indies, Faculty of Medicine, in Barbados on the diagnosis, and medical and surgical management of glaucoma.

St. Christopher's Hospital for Children, Philadelphia, announces the appointment of **Milton Sarshik, M.D.,** to the presidency of the executive committee of the medical staff.

In the glaucoma patient
on cerebral or peripheral
vasodilator therapy
no treatment
conflict
reported

VASODILAN®
(ISOXSUPRINE HCl)
the compatible vasodilator

- no reported increase of intraocular pressure.
- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.
- complications in the treatment of coronary insufficiency, hypertension, diabetes, peptic ulcer or liver disease have not been reported.

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[1-4] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[2,4] and observation of clinical improvement.[1,3]
Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODILAN tablets, isoxsuprine HCl 10 mg. and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories.

References: 1. Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. 2. Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. 3. Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. 4. Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

Mead Johnson
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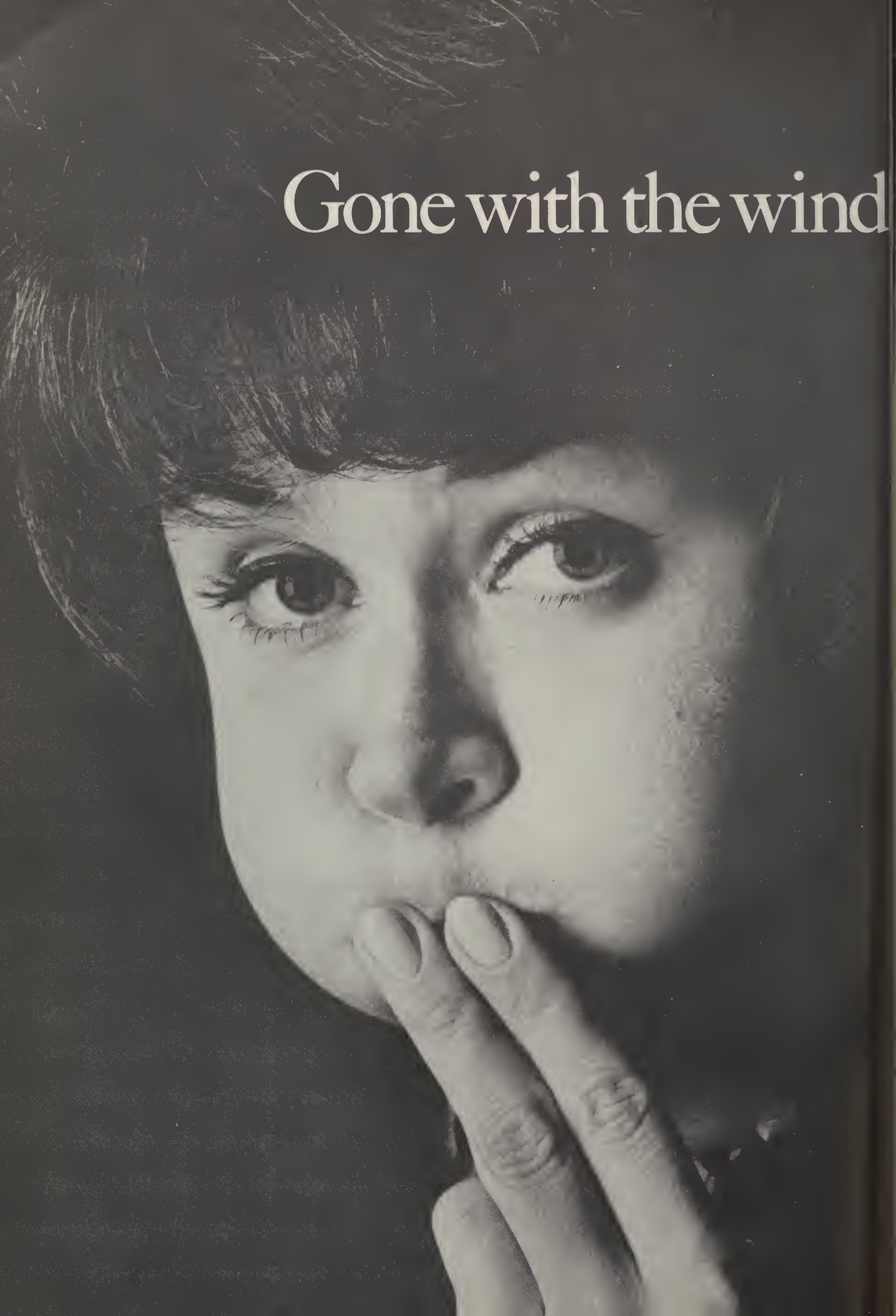
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The gas/acid group of disorders

"The two most common complaints referable to the upper gastrointestinal tract for which patients seek medical relief are hyperacidity and 'gas.' The two often occur together."*

Frees captured gas...neutralizes free acid

SILAIN-GEL Tablets and Liquid are separate formulas designed to provide equivalent dual-action symptomatic relief. Both dosage forms contain simethicone which effectively frees trapped gas, enabling the patient to eliminate it. Magnesium hydroxide in both assures a rapid rise in pH for prompt relief of hyperacidity. The special co-dried aluminum hydroxide/magnesium carbonate gel in the tablets assures the same rapid and uniform reaction rate as the liquid. Thus, both medications achieve prompt and prolonged neutralization of free acid *plus* prompt relief from the pain and pressure of trapped gas.

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The pleasant, distinctive flavor of SILAIN-GEL, as well as its non-constipating feature, make it a therapy your patients can live with—in comfort and without complaint.

Select the form of SILAIN-GEL you want to provide symptomatic relief in: gastric ulcer • duodenal ulcer • heartburn • gastric hyperacidity • gastritis • dyspepsia

when the patient prefers the convenience of a tablet, select
Silain-Gel® Tablets:

when the patient prefers a liquid, select
Silain-Gel® Liquid

Also available for the patient who needs an antifrothicant/antiflatulent agent only: **Silain®** (simethicone) Tablets

*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

Announcing the "Antgasid"

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Tablets: simethicone plus aluminum hydroxide/magnesium carbonate co-dried gel and magnesium hydroxide

Liquid: simethicone plus aluminum hydroxide and magnesium hydroxide

One dose does both: frees captured gas...neutralizes free acid

A·H·ROBINS A.H. Robins Company, Richmond, Virginia 23220

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in 2 ml. and 10 ml. vials...

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Upjohn THE UPJOHN COMPANY
KALAMAZOO, MICHIGAN

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.

The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

r headache, a sovereign remedy was wear a snakeskin round one's head.

A realistic approach to pain relief

'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
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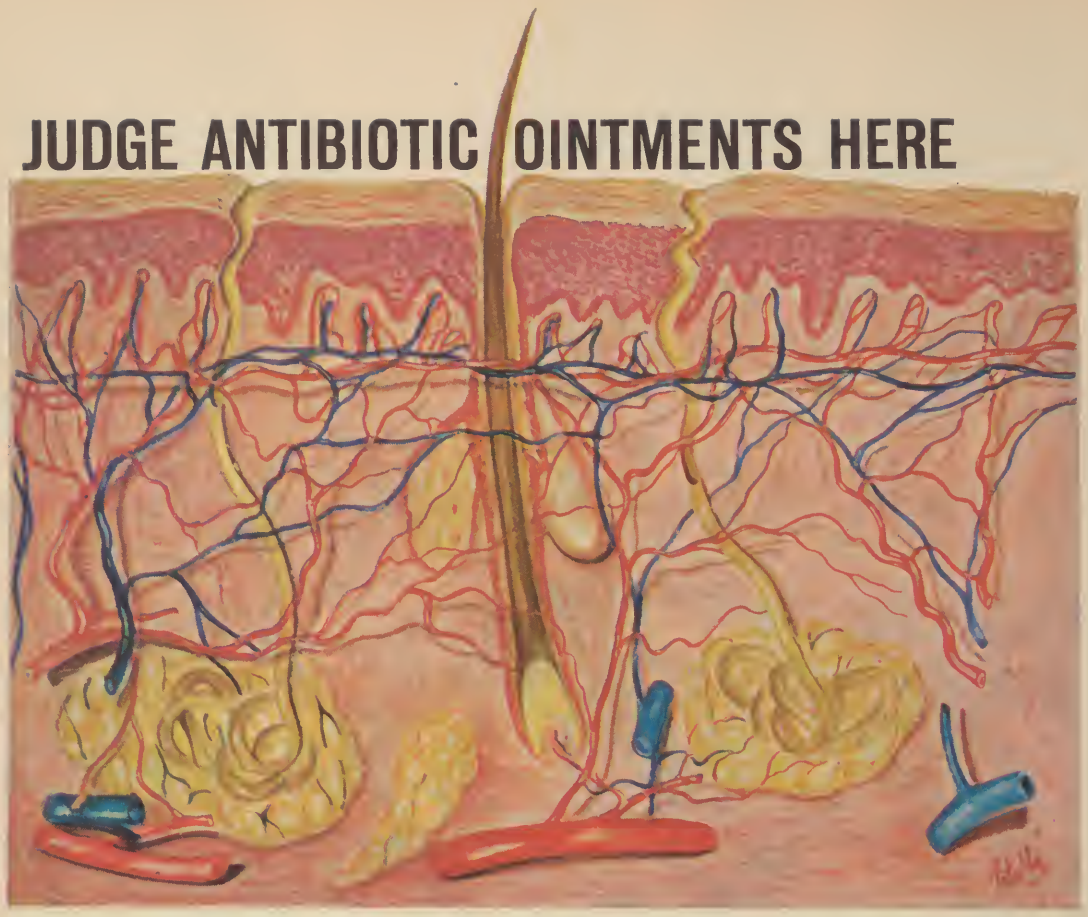

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No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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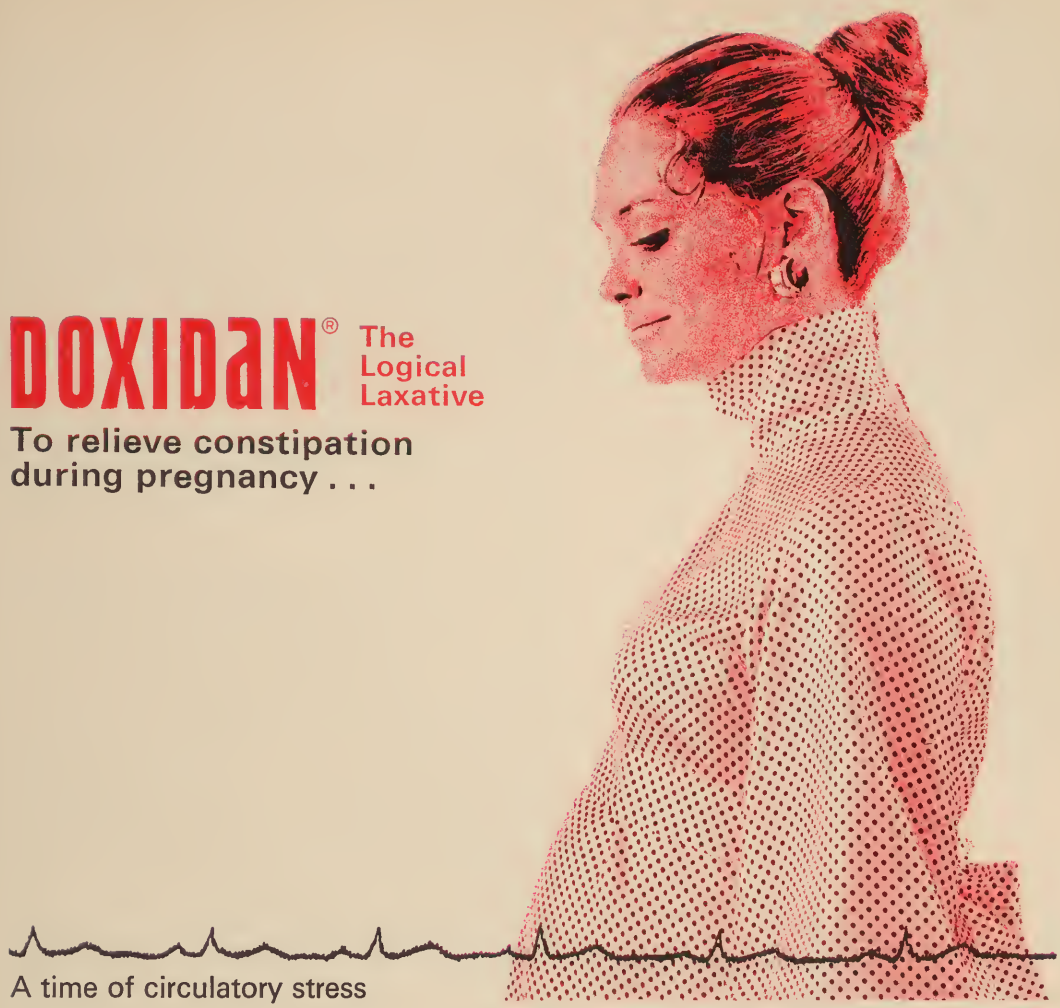
POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

DOXIDAN® The Logical Laxative

To relieve constipation during pregnancy . . .



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Doxidan gently relieves constipation in prepartum or postpartum patients and reduces the hemodynamic burdens of straining at stool.

gently . . . a highly effective fecal softener

predictably . . . a gentle peristaltic stimulant

economically . . . Doxidan costs less per effective dose*

Composition: Each capsule contains 50 mg. danthron N.F. and 60 mg. dioctyl calcium sulfosuccinate.

Dosage: Adults and children over 12—one or two capsules daily. Give at bedtime for two or three days or until bowel movements are normal.

Supplied: Bottles of 30, 100 (FSN 6505-074-3169) and 1000 (FSN 6505-890-1247).

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Somerville, N.J. 08876 U.S.A.

C-143

*based on actual drug store survey of prescribed dosages.

With QUĪ-A-ZONE — you can sedate effectively. A balanced combination of short, intermediate, and long-acting barbiturates (totaling 100 mg.) in a rapidly disintegrating tablet — sedation is provided within a few minutes . . . followed by sound restful sleep . . . usually without morning hangover. The four barbiturates in QUĪ-A-ZONE have dual channels of elimination (renal and hepatic) to lessen metabolic burden, decrease barbiturate retention, and minimize depression.

QUĪ-A-ZONE™

Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.
Usual Adult Dose: 1 to 2 tablets before retiring.
PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

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Susquehanna Valley Regional Medical Program — three years of progress

ROBERT M. FISHER
COMMUNICATIONS COORDINATOR

"What's a Regional Medical Program?

Insiders claim these were the first words spoken by Robert Q. Marston, M.D., to his deputy, Karl D. Yordy, after the two were named the first employees of the Division of Regional Medical Programs, Department of Health, Education, and Welfare (HEW) in February of 1966.

Five years later there still is no clear, one-sentence answer to Dr. Marston's question. As was the intent of the legislation which provided for their establishment, each of the nation's fifty-five regional medical programs (RMP) is different from the others. One wonders how they all came into being as a result of the same law.

Over the ensuing years they have been tempered by influences at the national level (including supplemental legislation in 1968 and 1970), at the regional level, and at the local level. Each RMP has taken shape the way the forces within that region have so ordained.

In Pennsylvania three RMP's have developed, each at its own speed and with its own emphases; and each is administered by a different kind of coordinating body. In eastern Pennsylvania, southern New Jersey, and Delaware the coordinating body is the University City Science Center. In the western part of the state, it is the University Health Center of Pittsburgh. In the Susquehanna Valley area the coordinating body is the Pennsylvania Medical Society.

Susquehanna Valley RMP entered what was to be a two-year planning phase with a grant award from HEW, effective June 1, 1967. Full-time staff activities began in November, 1967, with appointment of Richard B. McKenzie, PMS executive assistant, as director of the program.

Following the original application plan, the twenty-seven counties in the region were divided into four areas according to geography and medical care patterns. Area committees were formed consisting of persons nominated by concerned institutions and professional, public, and voluntary organizations in the region.

Through the work of the area committees and the eight categorical task forces which were appointed, problem areas were identified, solutions suggested, and concrete solutions were developed.

The planning period of SVRMP soon gave way to the operational phase in which, while planning was continued, SVRMP received federal support for a number of specific activities which had been proposed. The initial activities centered on continuing education and training, and demonstrations of patient care.

The latter area included support for equipping and training staff for coronary care units at five regional hospitals, and for renovating, equipping, and training staff for a stroke care unit at Mercy Hospital in Altoona. In addition, first-year support for the Susquehanna Valley Home Health

Services, Inc., serving Union, Snyder, and part of Northumberland County, was approved. Continuing education included a library information service provided in conjunction with PMS.

The information service, now beginning its third year with SVRMP and PMS support, is an extension of the tear sheet and photocopy service which PMS alone had previously provided for members. The service makes available to the region's physicians and other health professionals the facilities of the Milton S. Hershey Medical Center Library. Literature searches, bibliographies, photocopying, and loan of "hard copy" and audiovisuals are among the services available by writing the library or calling collect (717) 534-8646.

As SVRMP grew, so did the diversity of its activities. In the area of manpower, SVRMP's Radiological Health Training Program is training a new kind of health worker—the physics assistant. In a one-year curriculum at Geisinger Medical Center, SVRMP is supporting the training of twelve physics assistants over a three-year period. When trained, the assistants will be able to carry out routine tasks in x-ray calibration, radiation dose planning, radiation surveying, and nuclear medicine techniques, and will be familiar with the basic elements of the physics of diagnostic radiology.

SVRMP's aid to Columbia-Montour Home Health Services, Inc., helps bring a number of home services to residents of those two counties.

The "Dial Access" information service at Robert Packer Hospital, initiated by the Central New York RMP, now receives joint funding from SVRMP and provides five-minute "mini-lectures" on a variety of medical subjects.

Other current or recently-completed activities include:

- A pilot project for computerized analysis of EKG's.
- A study of the use of allied health manpower in medical practices.
- A regional program of coronary care unit evaluation.
- A series of technical surveys for selected hospitals.
- Support for a training program in enterostomal therapy.
- A screening program for asymptomatic urinary-tract infection.

SVRMP has developed all of its activites with the continuing advice and guidance of its voluntary groups including the Regional Advisory Group, area committees, and the Councils on Heart Disease, Cancer, Stroke, Education and Manpower, and Facilities and Services. PMS members make up over 40 per cent of the membership of these bodies.

Representatives of the Regional Medical Programs National Advisory Council, after a recent visit, cited SVRMP as a model for the fifty-four other RMP's across the country in the area of physician involvement and "grass roots" planning.

SVRMP brings people together to discuss matters of common concern. It encourages and stimulates cooperation—the basic ingredient for RMP progress.

Federally funded, but locally developed and administered, RMP represents a unique kind of government-provider relationship—one that is destined to succeed—one that must succeed. □

With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

EVAC-U-GEN®

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): ½ tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

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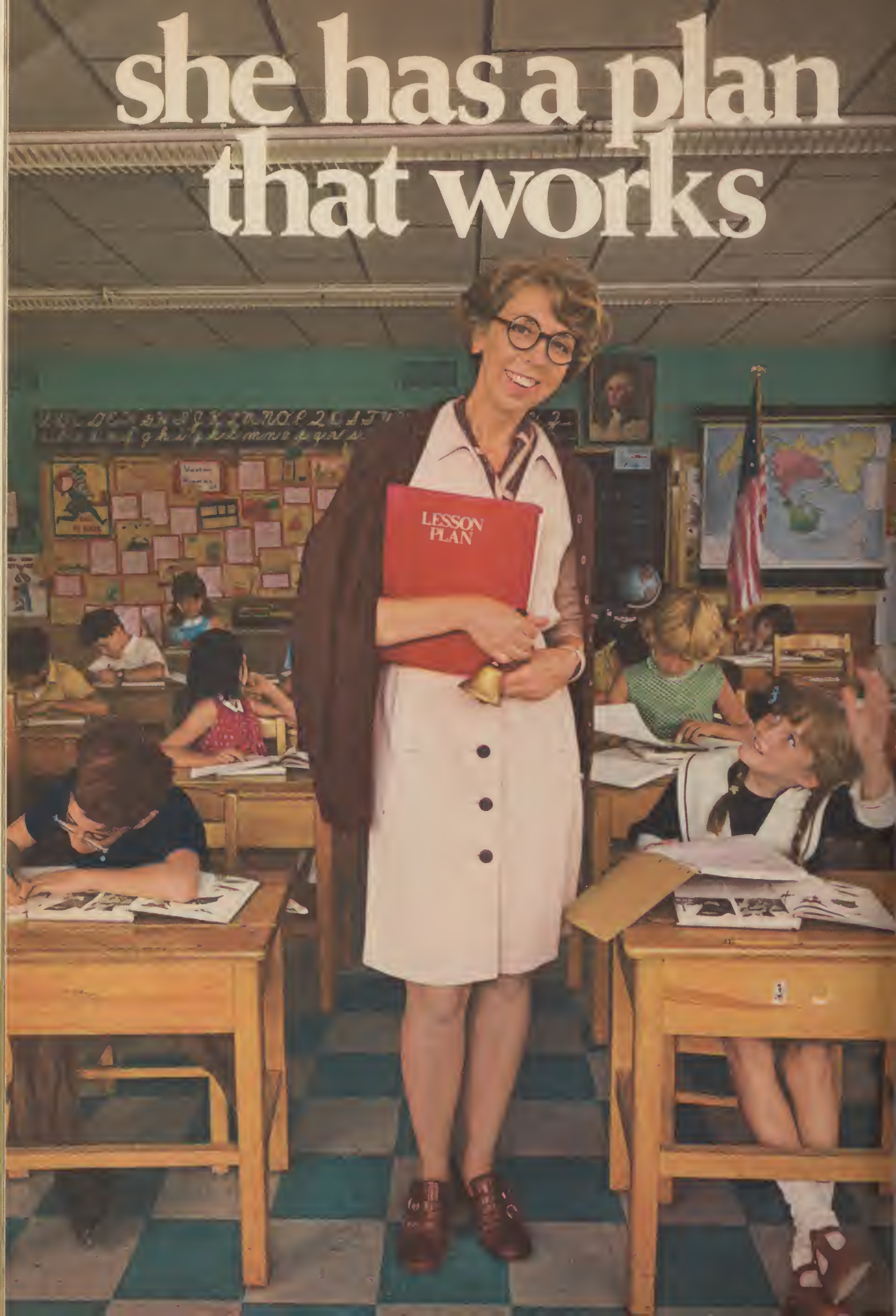
she has a plan that works



She has a plan that works.

She has one plan for the class. And they really respond.

She has another plan just for herself. A medication plan for her hypertension. And she's also responding beautifully.

More than just another antihypertensive, Ser-Ap-Es can be a whole medication plan for living with hypertension.

Does it get good marks for comfort?

Excellent. Because Ser-Ap-Es controls blood pressure effectively, dosage of each component is lower than if prescribed alone, usually minimizing side effects. However, side effects may occur (see prescribing information).

Designed with the kidney in mind?

Hydralazine maintains or increases renal blood flow.

And the brain too?

Hydralazine also relaxes cerebral vascular tone. And reserpine has beneficial calming action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

Practical on a teacher's salary?

Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits…

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

C I B A

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

a plan for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

INDICATIONS: All cases of hypertension except the mildest and the most severe.

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

Hydralazine: Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Reserpine: The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydralazine: Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

Hydralazine: Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Reserpine: Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

Hydralazine: Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE: One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

SUPPLIED: *Tablets* (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Summit, New Jersey

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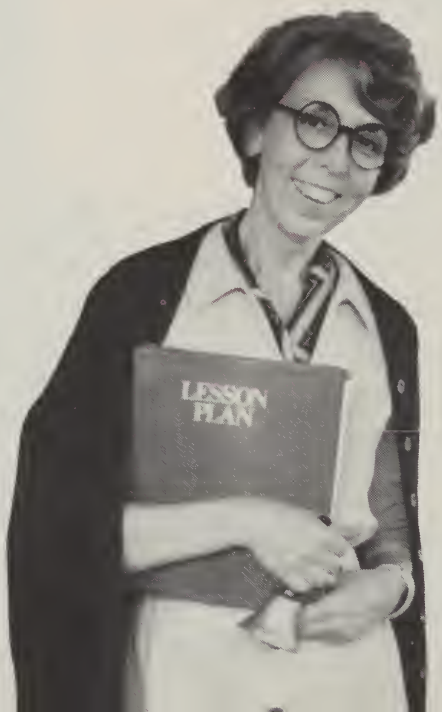

she has a plan that works for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

CIBA

The physician's role:

The Controlled Substances Act of 1970

MORRIS E. BLATMAN
Executive Secretary-Treasurer
Pennsylvania Pharmaceutical Association

On May 1, 1971 a number of Federal Laws will go out of existence, including the Federal Narcotic Act and will be replaced by Public Law 91-513 commonly called the Controlled Substances Act of 1970 (CSA).

Briefly the law requires that every person, not specifically exempted, who manufactures, distributes, prescribes, administers or dispenses any controlled substance, or who proposes to engage in any activity utilizing controlled substances must register annually with the Attorney General. The registration function will be the responsibility of the Bureau of Narcotics and Dangerous Drugs (BNDD).

The law recognizes five basic categories of Controlled Substances.

C I - L.S.D., marijuana, heroin, and all other substances for which there is no generally acceptable medical use.

C II - Opium and opium preparations. Chemical equivalents of opium or opiates, coca leaves and products of coca leaves, Methadone. Injectable forms of Methamphetamine. Also a long list of substances which can cause addiction or have a high incidence of abuse.

C III - Stimulants (amphetamines, phenmetrazine, solid forms of methamphetamine, etc.). Depressants (most barbituates, glutethimide, Nalorphine, plus narcotics formerly in Class "B" and Paregoric).

C IV - Barbital, chloral hydrate, phenobarbital, ethimamate, meprobamate, etc.

C V - Those preparations which were formerly listed as "exempt" narcotics.

For all ordinary use, substances in Schedule I are only available to persons specifically licensed to do research work. Possession of these substances without special authorization carries high penalties. There is a special set of penalties for possession of small quantities of marijuana.

Dispensing of Schedule II Controlled Substances

Schedule II controlled substances may normally be dispensed only pursuant to a valid written prescription. However, under certain emergency conditions, Schedule II substances may be dispensed pursuant to the oral authorization of a prescriber.

An "emergency situation" is one in which the prescriber determines:

"1. that immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user; and

2. that no appropriate alternative treatment is available, including administration of a drug which is not a controlled substance under Schedule II of the Act, and

3. that it is not reasonably possible for the prescribing practitioner to provide a written prescription to be presented to the person dispensing the substance, prior to the dispensing."

In such an emergency situation, the pharmacist may dispense a Schedule II controlled substance on an oral prescription provided that:

1. If the prescribing physician is not known to the pharmacist, he must make a reasonable effort to determine the legitimacy of the authorization, such as a check in the phone book to verify the prescriber's phone number, call-back, etc.;
2. The oral prescription must immediately be reduced to writing, containing all the information normally contained in a written prescription, absent the physician's signature;
3. The quantity must be limited to the amount required to treat the patient during the emergency period.

Thereafter, within 72 hours the prescriber must furnish the pharmacy with a written authorization for the emergency dispensing, which must be attached to the written notation previously made by the pharmacist and filed in the Schedule II prescription file. The burden of supplying the signed prescription is on the prescriber; and the prescriber, not the dispenser, will be penalized if this requirement is not satisfied. However, the pharmacy must inform BNDD if the prescriber fails to deliver the signed authorization as required. The pharmacy's failure to do so voids the original oral authorization, and makes the emergency dispensing unlawful.

Prescriptions for Schedule II substances may not be refilled.

NOTE: In a change from prior practice, partial filling of Schedule II prescriptions will be permitted if the balance is supplied within 72 hours. In a partial filling situation, a notation must be made on the prescription form and the prescriber notified.

The prescription label for a Schedule II controlled substance must contain:

1. Date of filling
2. Name and address of the pharmacy
3. Name and address of the patient
4. Name and registration number of the practitioner
5. Directions for use and cautionary statements, if any

Mr. Blatman prepared these guidelines for PENNSYLVANIA MEDICINE readers as a special service to the Pennsylvania Medical Society.

6. Warning on transfer to other than patient named on the prescription.

NOTE: The warning requirement is new. The address of the physician or the registry number of the pharmacy need no longer be placed on the label.

Schedule II substances will be identified by the symbol C-II.

Dispensing of Schedule III and IV Controlled Substances

Controlled substances in Schedule III and IV, whether narcotic or non-narcotic, may be dispensed pursuant to either a written or oral prescription. The usual requirement that an oral prescription be promptly reduced to writing and filed applies. As was the case for DACA drugs, a prescription for Schedule III and IV controlled substances may not be refilled more than six months after the date of issue nor more than five times regardless of the date. Upon each refilling, the pharmacist must note on the reverse of the prescription the quantity of drug dispensed, if less than the amount prescribed, the date, and the pharmacist's initials.

After the expiration of a Schedule III or IV prescription, additional quantities may be dispensed only on the basis of a new prescription.

Labeling requirements for Schedule III and IV substances are the same as those for Schedule II.

NOTE: Although former "Class B" narcotics are subject to more liberal dispensing rules under Federal law, the more restrictive requirements of state law will still be applicable in many states at least until state law is conformed to the new Federal law.

Schedule III and IV substances will be identified by the symbols C-III or C-IV, respectively.

Dispensing of Schedule V Controlled Substances

Controlled substances in Schedule V may be dispensed only for a legitimate medical purpose, and for some no prescription is required. However, only a pharmacist may dispense on OTC Schedule V substance; a non-pharmacist employee, even under the direct supervision of a pharmacist, may not. However, once the pharmacist has fulfilled his responsibility for determining medical need, the actual sale transaction may be completed by a non-pharmacist.

A purchaser must be at least 18 years of age and provide suitable identification. Not more than 240 CC. (8 oz.) of any substance containing opium, nor more than 120 CC. (4 oz.) of any other Schedule B substance may be sold without a prescription to the same purchaser in any 48-hour period.

A record book for OTC Schedule V substances must be maintained and must include the name and address of purchaser, the kind and quantity dispensed, the date of the transaction and the initials of the pharmacist.

NOTE: Paregoric, which could formerly be sold on a OTC basis under Federal law is now a Schedule III substance requiring a prescription.

NOTE: All requirements pertaining to Schedule III and IV substances are applicable to Schedule V substances dispensed pursuant to a prescription except that the refill limitations and label warning regarding transfer do not apply.

Schedule V substances will be identified by the Symbol C-V.

Warning Requirement

The dispensed container of all controlled substances in Schedule II, III and IV must contain the following warning:

"CAUTION: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed."

A strip-label or a pre-printed prescription label may be used to comply with this requirement.

Security for Storage of Controlled Substances

All controlled substances listed in Schedule II shall be stored in at least a securely locked, substantially constructed cabinet.

Controlled substances listed in Schedule III, IV and V must either be stored in such a locked cabinet or dispersed throughout non-controlled substances stock in such a manner as to obstruct the theft or diversion of the controlled substances.

NOTE: Former "Class X" products, including OTC's, are subject to this requirement.

All physicians and pharmacists who now have a Federal Narcotic License issued by I.R.S. will be automatically sent registration forms after April 30, 1971. However, registrations will be staggered over the entire year. Order forms will be required for all physicians and pharmacists desiring to buy controlled substances in CLASS II. Until new order forms are available existing narcotic order forms may be used. There will be no cost for order forms. Theft or loss of order forms must be immediately reported.

Annual registration for physicians and pharmacists will be $5.00.

The law is fairly specific about who must keep records. The physician is included if he dispenses drugs to patients and makes a separate charge or if his patients know that the cost of drugs is included in his regular fee. If he falls into either of the categories then he must take an inventory of all his drugs in Schedule II, III, IV and V on May 1, 1971. He must keep his purchase records available for authorized agents and will be required to repeat his inventory every two years.

In summary the new Federal Law changes a STAMP TAX ACT, I.R.S. LAW to one under the control of the Justice Department. It allows for emergency quantities of some narcotics to be dispensed on an oral order which must be confirmed in writing or the pharmacist is obligated to inform the Justice Department of the incompleted transaction.

More controls are to be exerted on the distribution of narcotics, tranquilizers, sedatives, and other items recognized as subject to abuse.

Both the pharmacist and physician will be required to keep better records of purchase and dispensing of these drugs and the Justice Department has greater powers in inspection, search, seizure and confiscation of these drugs in their manufacture and distribution.

As of this writing many regulations are yet to be released. Some of the above may be amended for clarification. Enforcement of many of these regulations will be dependent upon the amount of abuse that remains in the distribution network.

Scott asks closer look at FDA-proposed drug guides

Dr. Charles C. Edwards, Commissioner
Federal Food and Drug Administration

Dear Commissioner Edwards:

I am writing to express my deep reservations over the proposed combination drug guidelines published by the Food and Drug Administration in the *Federal Register* on February 18 of this year. Although I endorse the expressed objectives of safety and effectiveness for combination drugs, I am seriously concerned that these regulations, in practice, will have an adverse impact upon the pharmaceutical industry, the medical profession, and on society as a whole.

Immediately involved, as I understand it, are many hundreds of important and useful prescription and non-prescription drug products, on which thousands of patients are currently relying for their well-being. I have received a great deal of mail from constituents who fear that products they consider essential to their own good health may soon be taken away under the FDA proposal. The majority of these products, I further understand, have been on the market for many years.

Despite this, the Food and Drug Administration has now apparently decided to question the "rationale" for fixed combination drugs, and the degree of proof that should be required to assess the contribution each individual ingredient makes to the claimed effect of the product as a whole. I am not aware, however, that any question of *safety* is involved.

What I *am* aware of is the considerable apprehension within the medical and pharmaceutical fields expressed to me by professionals who fear that the FDA proposal will threaten the future outlook for pharmaceutical research by diverting resources of time and money away from the development of new drugs to the re-testing of drug products already considered safe for their prescribed uses. It has been suggested also that the FDA proposal will result in an unjustifiable interference with the prescribing and use of important drugs products. If this assumption is correct, such action would be in sharp contrast with the Nixon Administration's 1968 platform pledge of "diligence" in "protecting the traditional patient-doctor relationship and the integrity of the medical practitioner."

Moreover, it would appear that the affect of these regulations, if fully implemented, would be to significantly increase medical care costs not only to individual patients, but also to the Federal Government in its support of health programs. Such an increase would seem unavoidable if it becomes necessary to purchase individually those ingredients now available in single fixed-combination drugs.

Patient reaction and acceptance, I believe, also have to be considered. Obviously, a multiplicity of injections, if required, would increase patient discomfort. I see also a potential health hazard in the fact that some private individuals, lacking medical knowledge, may nevertheless attempt to put together their own non-prescription combinations in order to duplicate a product which they have found effective over the years, but which is no longer available.

Finally, I question whether your Agency has the authority to apply retroactively, to products which have long been regarded as safe and effective for their intended uses, the requirements for new drug approval contained in the 1962 amendments to the Federal Food, Drug and Cosmetic Act. This would appear to be contrary to the Congressional intent underlying the 1962 amendments.

In summary, I believe the FDA's February 18 proposal leaves unresolved serious issues of fact and law. I would urge, therefore, that the Food and Drug Administration carefully consider withdrawing this statement until a broader examination of its public policy issues can be undertaken. Specifically, I would respectfully request that the FDA consider not only the views of those with whom you have already conferred, but additionally, that extensive consideration be given to the valued professional judgment of a great many other medical practitioners, including persons highly regarded in academic medicine.

Your personal consideration and assistance will be greatly appreciated.

Hugh Scott, U.S. Senator
Pennsylvania

Governor declares
May 10-17 Medical Assistants' Week
Pennsylvania Medicine joins in tribute

Liberalized abortion laws as a social experiment

The indications for abortion have become an increasingly debatable issue for physicians with the adoption of liberal abortion laws by many states.

As with any change in social moves sanctioned by legislative action, new problems will most likely be created and some old ones intensified for the medical profession.

In this issue of PENNSYLVANIA MEDICINE, Sadoff and Owens write about the role of the psychiatric consultant in therapeutic abortion. The article, which merits the attention and thoughtful reflection of all physicians, appears on page 63. Another general article on abortion appears on page 59. Written by PMS Director of Communications Dane S. Wert, it is a timely account of facts on the subject.

Criteria defining what constitutes a contraindication for abortion at present are unclear from the psychiatric viewpoint. In those states where the abortion law has been liberalized, no provision has been made for specific psychiatric guidelines to assist in minimizing the risk of post-abortion "emotional harm." As a result, reputable hospitals and their abortion committees are facing the challenge of determining what their institutional policies and attitudes will be toward abortion performed for family, social, religious, or economic reasons. At present any changes will have to be made without the benefit of any generally acceptable specific psychiatric indications or contraindications that will protect the emotional well being of the patient.

It has been well documented that abortion as a surgical procedure carries little physical risk to the patient when performed in the hospital setting by well-trained surgeons or obstetricians.

If this were the medical profession's only responsibility, our problem would be simple. However, if we are to care for the patient as a total human being we cannot ignore the lack of reasonably specific psychiatric safeguards for these patients.

Since the revision of abortion laws is in reality a social experiment sanctioned by legislative action, the same precautions and protections should be applied as in a experimental procedure involving human lives. Heart transplant guidelines were established to protect the donor and the recipient well in advance of the first human heart transplant. Women subjected to social experimentation that exposes them to unknown risks should be afforded the same protection by the medical profession.

The paucity of psychiatric knowledge in this area requires that behavorial science studies be established to gather urgently needed data that will have prognostic value. Obviously this is not an easy task to undertake and is filled with opportunities for misinterpretation of data because of the emotional aspects of this issue. This should not deter efforts to acquire this knowledge by objective scientific studies.

Neighboring state legislatures have broadened their abortion laws. Little information has been obtained from their experiences. In Pennsylvania the legal situation awaits further court and legislative action to determine the legality of abortion. Perhaps now is the time to declare a moratorium on further liberalization of abortion laws in Pennsylvania while we try to learn from the experiences of our sister states. By so doing, we will be able to delineate more clearly the appropriate medical, legal and social indications for abortion.

DAS

Water pollution—physician challenge

The environment, and in particular water, has interested the physician since the early days of medicine. Hippocrates, in his work "Air, Waters and Places," dealt with urban development in Ancient Greece. This treatise was written as a guide for the physician to broaden his knowledge with regard to the environment in which he lived and worked.

Today as in the past, but to a more complex degree, we are faced with a serious problem of the conservation of our water quality and quantity. The problem of water pollution in this country is not a new one. It dates back to the era when John Smith floated up the Potomac River and found a shallow river with much silt and mud near the shore. The heavy sediment came from the intensive farming very early in our colonial history. Dredging of the Potomac began about 1805 and was continued unabated into the present and will go on into the future.

Because of the environment's direct bearing on the health of individual patients and because of its impact on health groups, it is logical now as it was in the past for the physicians to assume an active and responsible role in resolving modern health issues. In recent times the role of the physician has been assumed by other people through default, apathy or indifference on the part of the physician. The community expects to be advised by the physician on matters of environmental health and the physician should know the subject so he can converse intelligently about environmental health issues. Certain physicians such as industrial physicians, allergists, psychiatrists, epidemiologists, physicians trained in pulmonary or infectious diseases, preventive medicine, dermatology, and toxicology should be particularly interested. All physicians need to become involved in the problems of our environment and help guide the community in making meaningful and medically correct decisions with regard to this matter.

The rapid population growth rate, increased expansion of our urban centers with the formation of enormous multi city complexes, and the rapid development of industry and transportation has created massive problems of water pollution. There are new energy sources and synthetic chemicals as well as newly isolated infectious agents that contribute to our water pollution problems. Because we had an abun

dance of clean water, the public has developed poor habits and bad attitudes which have not changed rapidly enough. This has resulted in a problem of becoming "clean water" poor in certain areas.

Water pollution can take the form of solids, suspended solids, liquids, or gases dissolved in water. These can come from natural sources or be man made. Natural waters, however, have many living organisms which can drastically effect the course of events in a given water system. All of these substances, living and nonliving, may flow, disperse, or interact chemically and/or physically before they reach a final location such as the ocean or a receptor such as a fish, etc. or settle out on the bottom of the waterway. H_2O is an unvarying chemical compound and is never found as such in natural sources but is always contaminated. It is considered polluted if it is not suitable for its intended use: domestic, industrial, agricultural, propagation of fish, recreation, etc.

Organic pollution from sewage is a crucial problem. Many cities still dump untreated or primarily treated waste into our streams. In many cases streams are not able to assimilate the organic load. Moreover, sanitary and storm sewers are in many cases combined, causing all of the flow to go through the treatment facility.

Human waste is only part of the problem. One cow generates as much organic waste as sixteen human beings and in total, farm animals produce many times as much organic waste as human population. Much of this finds its way into our streams. With today's large facilities for growing farm animals, these units become troublesome problems that are rarely handled in a satisfactory manner.

Industrial activity is another great source of organic waste. Excessive organic pollution overburdens the capacity of the streams to purify themselves by bacterial degradation and reoxygenation, thus creating a eutrophication of the stream.

Inorganic materials such as phosphates and nitrates are very difficult to remove from sewage even by primary and secondary treatment. Part of the phosphates come from urine and feces. Detergents account for 30-40 percent of the polyphosphates. The people of Detroit and Cleveland may have clean *clothes* but tney are paying for that with a polluted Lake Erie. Nitrogen in various forms is used to fertilize fields for maximum production. Nitrogen, regardless of form, is converted to nitrate in the soil, and at least some of the nitrogen finds its way into our streams. Given water, sunlight, phosphates, nitrate, etc., algae blooms will grow and liberate oxygen. But on days when we have little or no sunshine, an anaerobic is created that may be unpleasant.

Metallic elements such as mercury are creating some concern because of the high concentration found in fish. Some fish now have such a high concentration that they are not safe to eat. Other elements such as copper and zinc when found separately in waters seem to have no deleterious effect, but when the same concentrations are found in combination, fish kills have occurred. In this regard it is worth keeping in mind reports suggesting that the incidence of certain forms of cancer and vascular disease are correlated with differences in geological formation and in the mineral content of water supplies. Hopefully more research in this area will be done.

Runoff can also hamper the assimilation of waste by causing small particles to be carried into streams. The water thenis polluted by solids, thus hampering the sunlight from penetrating into the water. This causes a decrease in the organic reduction by the organisms that require sunlight and consequently an anaerobic situation occurs in the stream. These small particles may settle out and build up on the bottom of the stream and cause a potentially hazardous situation.

In order for the organisms in air streams to grow to desirable populations and to assimilate the waste, certain temperatures must be maintained. Thermal pollution, that is the increase of the temperature of the stream by whatever means, causes an imbalance and undesirable effects in our waterways. Power stations, and in particular, nuclear power uses the water and generally returns it to our streams with an increase in temperature. This increase in temperature is enough in many instances to make an adequate stream degrade to a very undesirable state.

Radioactive spillage from atomic related industries may cause a great deal of radioactive pollution and could make the water supply deficient for many uses as well as increase the radioactivity of the plant life of the stream. Accidental spillage of radioactive material is also a constant possibility.

Determining the relative significance of man-made sources of water pollution is complicated by the fact that contaminants often enter water in a complex mixture whose specific chemical identities are largely unknown. This difficulty can be partially by-passed by describing stream pollution in terms of certain collective characteristics. One of these characteristics is the Biochemical Oxygen Demand (BOD) which is a measurement of the weight of dissolved oxygen consumed in the biological process of that degradable organic matter that enters our natural waterways. The demand that is put into our streams from a chemical standpoint is measured by the Chemical Oxygen Demand (COD) in a similar way to the BOD. Another collective characteristic is the weight of suspended solids only part of which are settleable. These are some of the parameters used to determine how efficient the treatment of our waste products are and how well a stream can handle a waste load.

The treatment of our domestic and industrial wastes are basically by primary, secondary and tertiary treatment. The primary treatment consists of sedimentation of solids which remove a large percentage of the BOD. The secondary system consists of the primary plus a biological system (usually trickling filter or activated sludge) to further reduce the organic material and in most cases there is also chemical coagulation used with these systems as well as chlorination of the effluent. Tertiary treatment includes the first two steps plus the use of lagoons to further help in the degradation process. This by far is oversimplification of the process but is only mentioned to acquaint the reader with the processes. In some cases these methods with all their expense and physical facilities are not sufficient to reduce pollution to a degree that the streams can assimilate the load without harmful effects. To add insult to injury most communities have combined sewage systems; that is, the sanitary and storm sewers are one system, and all this volume has to be treated at the treatment plant.

The medical aspects of polluted water have been observed over the years. While typhoid does not appear to be a significant problem in this country at the present time, other water-borne diseases have resulted from fecal or chemical contaminations. Serious epidemics of heptaitis have been traced to consumption of clams from areas polluted with large quantities of sewage. Death from *salmonella typhimurium* has been reported. Water-borne gastroenteritis epidemics have also been documented. Now mercury is reaching concentrations that are becoming alarming. Drinking water with elevated nitrate-nitrogen has been known to cause methemoglobinemia or cyanosis in infants. The long term effects of small amounts of pollution have not been well evaluated and in fact literature in this area is sparse.

Water means many things to many people. To some people, it is a lake on which to water ski or sail, to others it is a stream in which to fish or perhaps a pleasant place to walk beside. To some it is a place to dispose of waste. Recreation is a large industry in Pennsylvania today and it will probably continue to grow. Water, our most precious natural resource, must be preserved so that we can all benefit from its many uses. The physician should be involved because he, more than anyone else, is striving for better health for all individuals and the physician is the best qualified individual to lead such a cause. Too often individuals striving for political power assume the lead of such a cause and the end results are less than satisfactory. The health of our society could be at stake and rational judgments need to be made with respect to our environment. Let each of us show the leadership that he is capable of showing in an area that is ours to lead.

JOSEPH J. SCHWERHA, M.D., CHAIRMAN
PMS Commission on Environmental Health

'Let George say it'

The cruelest cut of all

GEORGE A. ROWLAND, M.D.
Millville

Family doctors have undergone much abuse over the past thirty years. They have been derided and called obsolete by specialists. Often the general public has considered them to be physicians of low stature. Only recently have their bloody and bandaged heads begun to be raised again as full scale members of the medical team.

In this respect it seems almost unfair that the president of the United States should have to uncover a brand new, highly lethal and possibly illegal, weapon to push them back down. It was as if he had unleashed an ICBM to destroy some unruly mosquitoes. The situation of which I speak was in the nature of a Christmas surprise. Like the visit of Santa Claus it was done silently without fanfare. Even now only a handful of people are aware of what happened.

It began with a bill named Yarborough-Rooney for its introducers in the House and Senate. Financially it was a midget carrying a price tag of less than five hundred million dollars. Looking back, its particulars were not earth shaking. It would have provided funds to medical schools to set up departments of family practice.

Some people feel that the only answer to the present shortage of medical care in the United States is to turn out more broadbased providers. So far very few schools have made any effort to improve their production of this kind of doctor. Only money can cause such a rapid reorientation. The AAGP strongly supported this bill. Leaders of the AMA backed them up. The few negative voices at the hearings were from government and the medical schools themselves.

It looked as though nothing could stop such a worthwhile endeavor. The Senate approved it with only one "no" vote. The House of Representatives did the same. Although the President was known to be antagonistic, there were plenty of votes to override a possible veto. Then came the Christmas present.

As every school boy should know, the president has several options with regard to a Congressional bill.

1. He may sign it, giving it his approval.
2. He can veto it, in which case it returns to Congress where he may be overruled by a two-thirds vote of each House.
3. He can fail to sign it and after fifteen days when Congress is in session, it becomes law without his signature.
4. His failure to sign when Congress adjourns within fifteen days constitutes a pocket veto and the bill goes into limbo and must start again at the bottom of the ladder if it is ever to become law.

It was a totally new maneuver that the White House arranged to celebrate this Christmas party. The bill had been passed in plenty of time so that Congress would remain in session for fifteen days thereafter. Unfortunately, as has been customary since time immemorial, Congress recessed for a very short Christmas holiday. This was all that was needed and it was announced that the bill was dead as the president had not signed it prior to the short recess.

This interpretation has been very upsetting to students of the Constitution. There is no record that any president in the past has ever used this gimmick. The matter is now being challenged in the courts. The outcome is far from assured. If the bill supporters are unsuccessful they will probably re-introduce a similar bill.

The question that comes to mind as a result of these shenanigans is why should anyone go to this much trouble to attack a relatively downtrodden group. It is hard to find anything really wicked in the features of the bill. Apparently, someone with the ear of the president felt strongly about the matter that they were prepared to alter the very procedures of government in order to attain the end. Who could it be?

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When girth gets out of control, TEPANIL can provide sound upport for the weight control program you recommend. EPANIL reduces the appetite—patients enjoy food but eat ess. Weight loss is significant—gradual—yet there is a rela- vely low incidence of CNS stimulation.

ntroindications: Concurrently with MAO Inhibitors, in patients hypersensitive to s drug, in emotionally unstable patients susceptible to drug abuse.

orning: Although generally safer than the amphetamines, use with great caution in tients with severe hypertension or severe cardiovascular disease. Do not use dur- g first trimester of pregnancy unless potential benefits outweigh potential risks.

dverse Reactions: Rarely severe enough to require discontinuation of therapy, un- easant symptoms with diethylpropion hydrochloride have been reported to occur re atively low incidence. As is characteristic of sympathomimetic agents, it may cas'onally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulacytosis, and leukopenia. A variety of miscelloneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-107/4/71/U S PATENT NO 3,001,910

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Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

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Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
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PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps

when an unnerving experience compounds the pain

the compound analgesic that calms instead of caffeinates

In addition to pain, this patient has experienced anxiety, fear, embarrassment, and frustration. No doubt these psychic factors actually increased her perception of pain. Surely the last thing she needs is an analgesic containing caffeine. The logical choice is Phenaphen with Codeine. It provides a quarter grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can control the pain more effectively. It's no accident that the Phenaphen formulations contain a sedative rather than a stimulant. Don't you agree, Doctor, that psychic overlay is an important factor in most of the accident cases you see?

Phenaphen®

with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming). **Indications:** Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.
A. H. Robins Company, Richmond, Va.

A·H·ROBINS

'head clear upon arising'

For upper respiratory allergies and infections including the common cold, Dimetapp Extentabs® effectively relieve the stuffiness, drip and congestion all night and all day long on just one Extentab every 12 hours. For most patients drowsiness or overstimulation is unlikely.

prescribing information appears on next page

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Dimetapp® Extentabs

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg

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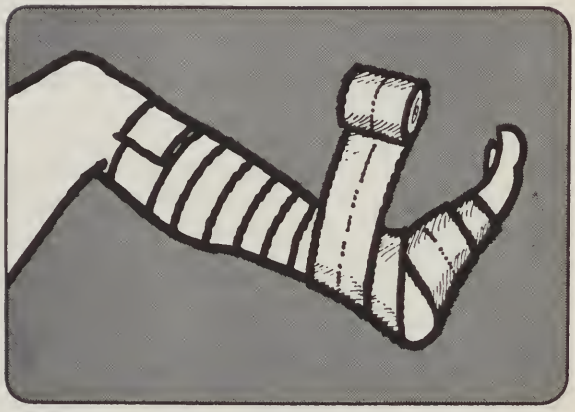
INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.
HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.



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Why Fuss With Proctoscopy?

VICTOR GILBERTSEN, M.D.
Assistant Professor of Surgery
Director of
University of Minnesota Hospital

In the detection and diagnosis of internal cancers, proctosigmoidoscopy is by far the most efficacious available diagnostic procedure, and, in fact, is of such outstanding merit as to permit detection of more potentially curable visceral cancers than found by all other endoscopic procedures combined *plus* the total of all available contrast media diagnostic x-ray procedures.

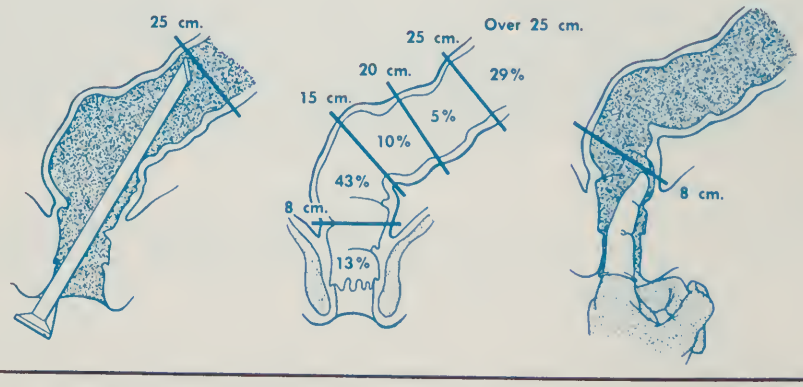
The results of a twenty-year study at the Cancer Detection Center at the University of Minnesota, which now include more than 80,000 proctoscopic examinations of persons 45 years of age and older, show, in addition, that extensive specialized training is not required to perform this examination, that the procedure is not excessively time-consuming, that patient tolerance and cooperation nearly always are excellent, that anesthesia is seldom, if ever, required, and that inadvertant intestinal perforation, while obviously a consideration, has only occurred three times in the 80,000 examinations which have been done at the Center.

Cancer of the large intestine is the most commonly-occurring visceral neoplasm in this country, has caused more deaths during the past 50 years than any other cancer, and for most patients the diagnosis continues to be made only after the growth and spread of the tumor make futile best efforts for cure of the disease. Two-thirds of the cancers which occur in the large intestine, by fortunate circumstance, are primary in the distal 25 cm of large bowel, the area which permits direct proctosigmoidoscopic visualization of even the smaller lesions.

The observation is neither new nor unique, of course, · that proctosigmoidoscopy is indicated as a portion of the evaluation of patients with a history of rectal bleeding, of those with complaints suggestive of hemorrhoids, for patients with a history of a change in bowel habits, for older persons with unexplained anemia, and for patients with a number of other findings: the indications for proctosigmoidoscopic examination are well established in circumstances such as these.

The somewhat newer concept, and one worthy of our attention, is that of making the diagnosis for patients with cancers of the lower bowel *prior* to the time of the appearance of symptoms which force the patient to seek medical help and which suggest to the physician the possibility of serious illness. The extensive experience of the Cancer Detection Center study strongly suggests that once patients are on a program of routine, annual proctosigmoidoscopic examinations, the risk of death from cancers primary in the distal 25 cm of bowel is very nearly entirely obviated and the indications for extensive surgical procedures markedly reduced.

Thus, for the patient with symptoms suggestive of the possibility of intestinal cancer the usual standards of good medical practice require the consideration of proctosigmoidoscopy as a portion of the examination; and for patients— especially those in the 45 and older age group— for whom the physician desires to offer the opportunity to markedly reduce the risk of death from intestinal cancer, routine periodic proctosigmoidoscopy is a procedure to be strongly considered in any program of comprehensive medical care.



CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.

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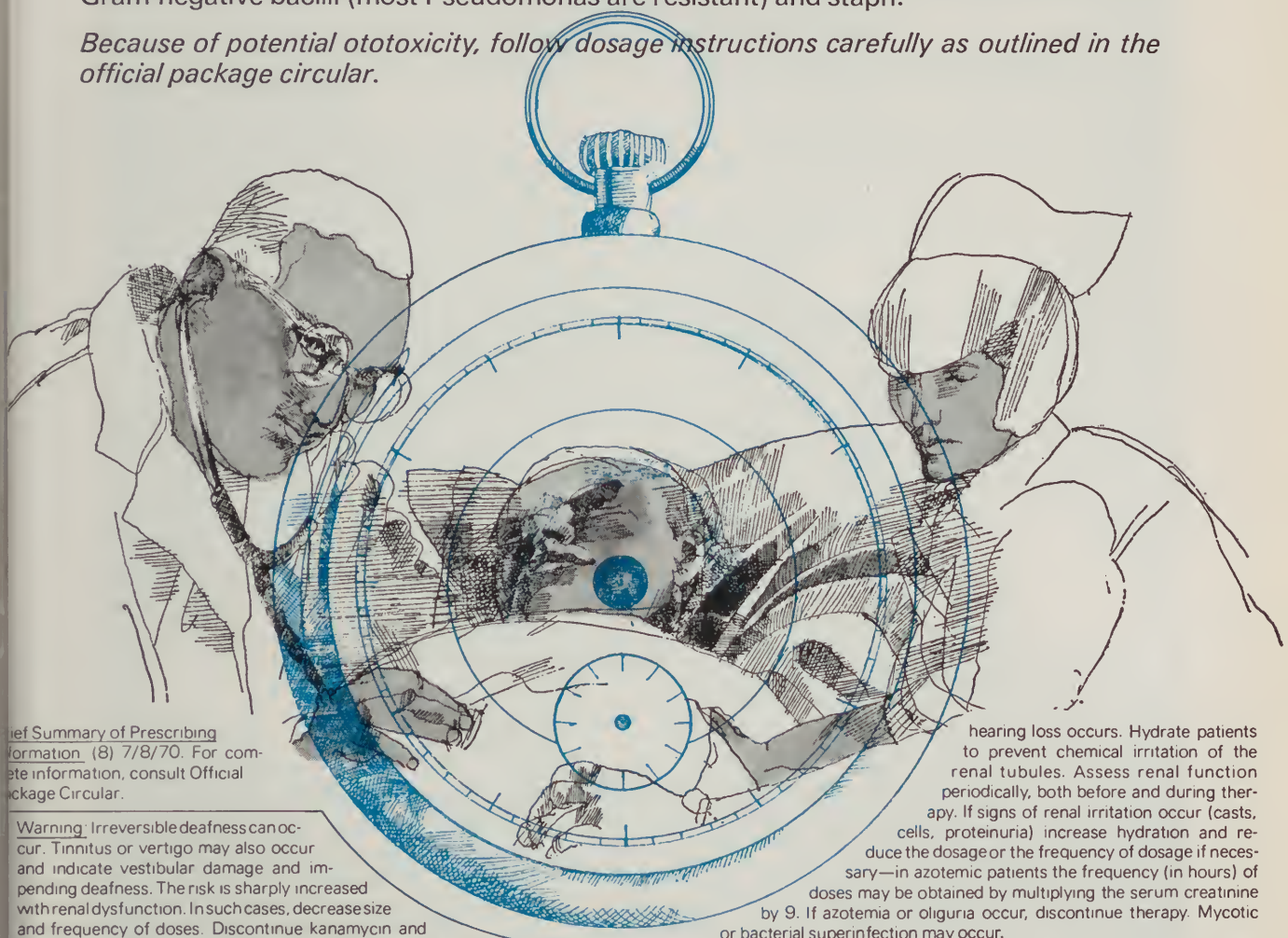

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Allegations, Actions, and Ad interim . . .

DANE S. WERT
PMS Director of Communications

Abortion.

The very word sets off emotional skyrockets and in a discussion of it, objectivity exists to about the same degree as asexuality in a college coed dorm.

That is, it undoubtedly is there but human nature raises questions about the degree.

Pennsylvania's legislators successfully avoided the issues involved three decades ago when they passed the state's existing law which declares that illegal abortions shall not be performed and then never defines what an illegal abortion is.

Court Decision Awaited

That law has been declared unconstitutional by two county courts in Pennsylvania and a state Supreme Court decision on it is pending and expected momentarily. One of the county courts, in Allegheny, not only declared the law unconstitutional; they urged the General Assembly to "come to grips with the revisions necessary."

Anticipating that the state Supreme Court will uphold the county courts—and soon— the Philadelphia Board of Health has started drafting regulations for controlling the performance of abortions in that city.

Several related questions are pending before the U.S. Supreme Court. One asks the court to rule on the constitutionality of any law that makes abortion other than a decision to be arrived at between the woman involved and her physician.

Counter to the thrust of such appeals is one instituted by two Pittsburgh physicians who have asked the State Supreme Court to decide if an unborn child has the right to live. They are appealing an Allegheny County Court of Common Pleas ruling that an unborn child has no rights under the Fourteenth Amendment of the U.S. Constitution unless the child subsequently is born alive. The Amendment is the "equal protection of the laws"— one which also specifies that no person shall be deprived of life without due process.

A bill was introduced in the 1970 state legislature to define a legal abortion as one performed by a physician or by someone working under the supervision of a physician. It made no mention of the consent of the woman involved, but related court decisions make such consent a practical necessity. That bill would have established "abortion on demand" in Pennsylvania. It died in committee.

Abortion became for a time a very hot 1970 gubernatorial campaign issue, but both candidates eventually established themselves as being in favor of apple pie and motherhood.

New Bill Introduced

In mid-March the 1971 state legislature received a bill slightly revised from the one that was introduced last year but which essentially remains "abortion on demand" legislation. The new bill would establish the right of any woman to an abortion provided that her request is made prior to completion of 16 weeks of pregnancy. It does not specify a time limit for the abortion itself. It also deviates from the previous measure in that it would limit the performance of abortions to "a physician duly licensed to practice medicine in this Commonwealth..." instead of allowing someone working under a physician's supervision to handle the procedure. It specifies that

PROOF

the abortion take place "in an accredited hospital or other medical facility." The previous bill would have allowed office abortions. The term "other medical facility" could pave the way for the establishment of abortion clinics. It adds that no hospital, facility or physician could be required to perform an abortion. The prime mover is Representative Gerald Kaufman, Allegheny Democrat, but the bill has bipartisan co-sponsorship.

National Law Possible

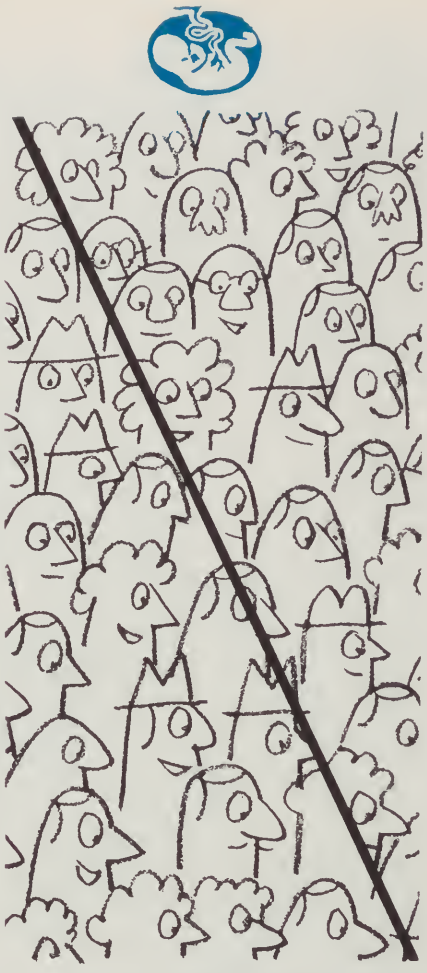
In the Congress, Sen. Robert Packwood of Oregon has announced that he plans to introduce a bill to bring abortion under federal control and thereby establish "abortion on demand" nationally. Passage of any such national legislation undoubtedly is many years away if it ever achieves passage. Meanwhile, it is much more likely that a Supreme Court decision will allow the Congress to avoid the whole issue. There is current speculation that the court will declare that any state laws restricting the availability of abortion are an infringement on individual rights, but at some point the question of the rights, if any, of the fetus also may reach the Supreme Court and then the primary question may focus on the establishment of the point in time at which the embryonic cluster of cells becomes a human life with the right to equal protection under the law.

Court decisions in all states allow recovery for prenatal injuries, sometimes even for those occurring as early as the first month of pregnancy. In several jurisdictions, it has been established that the fetus is a separate entity entitled to damages itself.

In the absence of a Solomon and in the presence of all of the martialed forces that exist, court decisions may establish legal guides but it is doubtful that they will resolve the controversy.

If the courts should consider "rights of the fetus," the result could be declaring unconstitutional "abortion on demand" laws that exist in several states, the most notable of which, from Pennsylvania's viewpoint, is New York. Despite claims to the contrary, however, courts generally reflect social changes rather than form them.

Social attitudes are changing, but the degree of change is not as great as the sound and fury of the change



would indicate. Recent public opinion polls show an almost equal division between proponents and opponents of "abortion on demand."

AMA Position

The abortion controversy setting differed only slightly from that of today when in June of 1970 the American Medical Association House of Delegates adopted a new abortion position as follows:

"Abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only after consultation with two other physicians chosen because of their professional competency, and in conformance with standards of good medical practice and the medical practice act of his state."

Interpreters of the AMA policy say that it allows for the ethical performance of abortion for social and economic reasons, in addition to medical reasons, as long as the physicians involved feel that it is in the best interest of the woman.

Four months later, the Pennsylvania Medical Society House of Delegates met in Lancaster and reconsidered what its abortion policy should be. Before the House was the recommendation of the Board of Trustees that the 1970 abortion reform bill in the state legislature be supported, a position tantamount to supporting "abortion on demand". Also before the House was a resolution that underwent some last minute rewriting to modify slightly its call for support of "abortion on demand."

Discussion of the central issues involved took place in the reference committee hearing. When the reference committee report reached the floor of the House, the basic issues were not debated. The only floor discussion involved relatively minor components of the report.

The House adopted the reference committee report which was a reiteration of the position adopted in 1967, with the additional instruction that the State Society should seek to have its position become a part of any abortion bill introduced in the state legislature.

PMS Position

The State Society position declares that an abortion may be performed only when: "(1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother; (2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or both; (3) There is documented medical evidence that continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest, may constitute a threat to the mental or physical health of a patient; (4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and (5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals."

Floor discussion prior to passage of this position largely concerned itself with items four and five. The argument was presented that the concurrence of two other physicians who have examined the patient would do little more than increase the cost of the procedure. Others argued that limiting

abortions to hospitals also would increase the cost of the procedure; but proponents of the position noted that the position does not say the woman must be admitted to the hospital—that the procedure could be performed on an out-patient basis. There was a further discussion that limiting it to hospitals accredited by the Joint Commission does not recognize osteopathic hospitals, but this discussion did not result in any change in wording.

Some attorneys and others have pointed out that statements which use the terms "life" or "health" in attempting to define indications for abortion are using terms that are no more than linguistic abstractions. For instance, they point out that the word "health" does not leap from the page to offer the physician, judge, jury or prosecutor a list of specific physical and mental conditions or symptoms that signify a danger to health. It is maintained that such abstract terms are mere tools for communications that do not have any "correct" definition or usage and thus always will result in interpretations that differ from person to person.

Because of the tempo of the abortion controversy throughout the state at the time, dozens of requests for the State Society position and an explanation of it poured into the PMS headquarters office. A statement explaining the general philosophy of the State Society position was prepared and has been distributed upon request along with the five points in the position. The distributed explanation reads as follows:

"Essentially, the Pennsylvania Medical Society position specifies that there be recognized medical reasons for performing an abortion rather than social reasons.

"So-called 'abortion on demand' legislation makes the procedure available to all who want it for either medical or social reasons or a combination of both. For instance, such legislation would enable a woman to have an abortion performed legally just because she wants an abortion. She could be in good physical and mental health, the fetus may be presumed to be normal, the process of childbirth and rearing another baby may pose no threat to her physical and mental health, and she still would be entitled to an abortion in a state where 'abortion on demand' legislation exists. Under those circumstances, there may be social justification for such an abortion but no specific medical justification.

" 'Social justification' might include abortion as a form of population control or as a means of avoiding the social stigma attached to unwed females becoming mothers, just to mention two examples.

"The Pennsylvania Medical Society favors family planning and through it, population control, but it does not recognize abortion as a medically accepted method of family planning or population control. Proponents of the medical society position point out that conception prevention medication, devices, and methods are readily available and are even provided upon request through Pennsylvania's 'medicaid' program for the medically indigent. The position favors conception prevention where such prevention is desired. Inherent in it is the awareness that although a modern medical abortion is a relatively safe procedure, it nevertheless carries some small risk to the health of the patient.

"If we take the example of an unwed pregnant female, the Pennsylvania Medical Society position well may permit an abortion to be performed if the three physicians specified agree that the female's emotional reaction to the social stigma that may be attached to becoming a mother is such that it poses a threat to her mental health. The position also would permit an abortion if the female had been forced to submit to the intercourse at which conception took place or had participated in the intercourse prior to the legal age of consent, i.e., legally established forcible or statutory rape. Many physicians may maintain that virtually all circumstances of a pregnancy resulting from statutory or forcible rape or incest pose with the pregnancy and the eventual birth of the child a very real threat to the mental well-being of the female and the Pennsylvania Medical Society position would countenance an abortion under those circumstances when three such physicians so agree.

"For a contrasting and admittedly bizarre counter situation, the Pennsylvania Medical Society position would not countenance performing an abortion on a woman for the sole reason

that she may prefer to go on a trip to Europe rather than have another child.

"Although the Pennsylvania Medical Society position on abortion may be regarded by some persons as being 'very conservative,' from the above examples it should be evident that it is quite liberal in its definition of medical justification even though it may not be as liberal as some persons may wish it to be for social reasons.

"The Pennsylvania Medical Society is, essentially, a medical organization although the inference should not be drawn that it never makes policy decisions affecting social components. However, in the instance of the abortion position, the reasons cited were completely medical and thus are, in the opinion of the Pennsylvania Medical Society, the only justifiable ones for interrupting a pregnancy."

Physician Opinion Divided

The two camps of State Society members at the extremes— those who favor "abortion on demand" and those who oppose abortion for virtually any reason— are both unhappy with the State Society position, challenging its propriety and many elements of the explanation.

Liberal abortion proponents claim that medical justification for the position breaks down when one considers the fact that abortion prior to about the eighteenth week has an incidence of complications that is less than that associated with routine tonsillectomies, that the risk to the mother in early abortion is less than that involved in carrying to term and delivery, and that the procedure thus might be "medically indicated" in any pregnancy where abortion is requested. Those in opposition to that position respond by saying that extension of that argument would have physicians seeking out pregnant women and urging them to have abortions as a health measure in any instance where there were not overriding psychological needs for motherhood. However, the crux of virtually where many women still choose the back alley route rather than to be identified through the established procedure.

There is a growing body of feeling that a system not yet tried in any country should be tried in the United States. This is repeal of all abortion laws, leaving the matter of abortion to be determined by the woman and her physician, subject only to the laws governing medical practice.

As the argument continues, ads are appearing in Pennsylvania newspapers and magazines to proclaim the availability of an abortion for anyone who wants it through a variety of New York referral services and clinics, and an increasing number of patients are contacting Pennsylvania physicians with the question, "If I can get an abortion in New York any time I want it, why can't I get it here?"

One recent issue of a university newspaper in Pennsylvania carried four different advertisements from abortion referral services. It is estimated that 500,000 abortions a year is the current New York rate and that approximately 60 per cent of them are performed on out-of-state residents.

There have been claims that "abortion on demand" legislation is one way to wipe out back alley abortionists and the high incidence of complications in such illegally performed abortions. That seems logical, but there is very little evidence that there has been any major decrease in illegal abortions in states with liberal abortion laws, where many women still choose the back alley route rather than to be identified through the established procedure.

Regardless of medical society positions or court decisions, abortion apparently has existed in every culture and sub-culture. There is one tribe that pretends it knows of no relationship between intercourse and pregnancy, but even in that group abortion is practiced.

The reasons given for abortion in the various cultures and sub-cultures and by the various individuals involved would be extremely familiar to any physician who has even been confronted by a pleading woman who doesn't want to be pregnant. The pleas apparently are as universal as abortion itself.

Not all abortion methods are universal. For instance, anthropologists report that several tribes of Plains Indians routinely placed a plank across the abdomen of a prone, gravid female and then a number of women would jump up and down on the plank until the blood sported from the vagina. The practice played hob with female mortality in the tribe, but under those most extreme of circumstances, abortions were requested and performed. That abortion took place at all in that subgroup may indicate how universal the act of abortion really is.

A number of studies lead anthropologists to say that the number of abortions can be increased by the passage of liberal laws but that no law and no social attitude can eliminate abortions entirely.

On the fair assumption that this is true, all we need do to resolve at least a part of the abortion issue is to determine in which pregnant females the act of inducing an abortion is inevitable and then perform it professionally under ideal circumstances.

Naturally, to make that determination you'll need another Solomon— or the modern day substitute, two concurring psychiatrists.

All of which leads back to...

"Abortion.

The very word sets off emotional skyrockets and in a discussion of it, objectivity exists to about the same degree as..."

The Psychiatrist As Consultant For Therapeutic Abortion

ROBERT L. SADOFF, M.D.
ROGER OWENS, B.A.
Philadelphia

RECENTLY much has been written on the liberalization of the laws on therapeutic abortion in many of our states. Most physicians tend to support the changes in the law and the broadened criteria for this procedure. Thurstone (JAMA, July 14, 1969) cites statistics that reflect these changes and notes also that the procedure is relatively safe, with few complications.

Most hospital abortion committees require letters from one or two staff psychiatrists, approving or recommending the procedure. Generally, the function of the consulting psychiatrist has been to provide psychological justification for the abortion to meet legal criteria.

The more difficult task of evaluating the effect of the abortion on the patient is less frequently considered, primarily because most reports have shown little or no adverse reactions to the abortion. Acute depressive reactions usually remit spontaneously following the procedure, and no one has reported a case of suicide following and caused by a therapeutic abortion.

This paper will emphasize the need for a careful consideration of post-abortion mental state by the psychiatric consultant. The first case presented represents a delayed depressive reaction to a therapeutic abortion.

Case Report

Mrs. S. is a twenty-six-year-old divorced, Negro, who presented to the Temple University Psychiatric Department with complaints of chest pain, depression, anxiety and nausea. "Like I was when I was pregnant." She gave a history of having been increasingly depressed over several weeks, with some consideration of harming herself, or taking her own life. She said, "I just wanted to leave my children and my family and get away." She had been unable to work for two months and had been unreliable on her previous job. She has been planning to marry a man twice her age for "security" but not for "love."

Her past history reveals that she was the second of four children, born to an alcoholic father and an unstable mother. Her childhood was complicated by many disagreements and violent arguments between her parents, finally ending in divorce when she was twelve years old.

Her early sexual relationships were limited to her boyfriend, by whom she became pregnant at age sixteen. This necessitated her dropping out of school and marrying the father of the child. Following the birth of a second child two years later, the marriage terminated in divorce. She experienced a spontaneous abortion in 1964, with a diagnosis of chronic endocervicitis. In March, 1966, she bore a child to another man and nine months later had a D & C for septic abortion. In September, 1968, she became pregnant again, resulting in depression, suicidal ideation and extreme emotional tension. She applied for a therapeutic abortion which was granted when the foetus was five months. She had felt the "quickening" and had some reservations about having the procedure done, but decided that she could not have another child to care for when the other three were already on welfare. In addition, she requested that her fallopian tubes be ligated so that she would not become pregnant again. She was able to handle her feelings by denial and repression for several months, but as the anniversary date of her decision to terminate her previous pregnancy arose, she became increasingly anxious and depressed. Also, as she contemplated marriage with her new boyfriend, her sterility and inability to 'make up' for the loss of the other child became more significant. It was at this time she requested psychiatric help for her depression.

From a psychodynamic point of view, Mrs. S. is a fairly hysterical young woman whose typical defenses of repression and denial were inade-

quate to meet the current life stress. Because of the breakdown in her weak defenses she became depressed and anxious. In discussing the problem with her she indicated that she had been ambivalent about having the procedure all along and that she was no longer able to deny that she had "killed her child." She was feeling guilty and could not make up for it by having another child. She could rationalize not bringing a fourth child into the world; however, this intellectualization was not sufficient to overcome her guilt and resulting depression.

Psychiatric consultation for Mrs. S. must consider her request for therapeutic abortion independently from her request for tubal ligation. Her ambivalence regarding the abortion was obvious and should be an important element in the evaluation for the procedure. In addition, a patient is more likely to feel guilty and have depressive symptoms following a therapeutic abortion after "quickening" is experienced. Psychologically, the pregnant woman usually experiences "a feeling of life" within her once she has felt foetal movements. Subsequent guilt usually focuses on "getting rid of" something that has been living and moving within, and is much less likely to occur before quickening.

A separate evaluation must be conducted with respect to tubal ligation. Social and economic factors undoubtedly enter the picture, but so do age and potential for remarriage. In the case of Mrs. S., there is no question that her depression was aggravated by her inability to produce another child with her new husband.

It is quite easy for the physicians examining a patient in post-abortion depression self-righteously to criticize the judgments of their colleagues who had recommended the procedure. This paper is not intended for that purpose, but rather to share with our colleagues the difficulty in performing our tasks when recent changes in legislation have occurred, demanding an unusual burden on the psychiatrist.

No longer can the consulting psychiatrist consider only the suicidal potential of the pregnant woman if her request for a therapeutic abortion is not granted. Currently, there are a number of medical, family and social psychological factors to be weighed and evaluated. The following case will illustrate the difficulties presented and the potential for emotional harm to the patient, whether she has her pregnancy terminated or not.

Case Report

After careful evaluation it was revealed that the unmarried, twenty year old woman did not wish to have her pregnancy terminated except under the coercion of her parents. She wished to marry the father of the expected child, but this marriage was opposed by her parents. It was obvious that the two youngsters had brought the situation to a crisis by the pregnancy. Religious, economic and philosophical differences existed between the boy and the girl's family; introduction of a child at this point would have added to their difficulties.

The young lady was quite mixed about her feelings or she would not have come to the interview at all. Though she said she did not wish to have the abortion, she indicated she would do it or her parents would become ill and she would feel responsible. She would also be "cut off" from the family - a situation which she could not endure, and had been persuaded by her parents that the baby would only add to her burdens. In a sense, the girl was saying that she would have the abortion so that she could continue her anger at her parents and blame them for "making me get rid of the baby." If she allowed herself to have the baby she would risk losing her parents' support and would need to take the responsibility for her marriage and the baby upon herself. This latter obligation she could not incur.

The consulting psychiatrist has an obligation to spell out these difficulties to the family and to the referring physician. The decision for having the pregnancy terminated rests with the patient and her family. In weighing the factors involved that could lead to subsequent mental illness, it was decided that less serious emotional disturbance would ensue if the pregnancy were terminated, but a post-abortion depressive reaction would probably occur and should be anticipated and treated at its first appearance.

These cases are presented to illustrate the demands made upon the psychiatric consultant in a therapeutic abortion and for each consultant to be aware of the appropriate criteria and possible complications which may occur. The psychiatric role as consultant can be clarified if the criteria for abortion are clarified and not lumped into "psychiatric criteria." Social and economic factors account for most requests for therapeutic abortions. The psychiatrist should not allow himself to be called upon routinely in order only to justify legal procedures, but primarily to evaluate the effect of the abortion upon the patient.

This last point is highlighted by the report of the Group for the Advancement of Psychiatry, ("The Right to Abortion: A Psychiatric View"), which takes the position that the revision of abortion statutes of some states broadening the grounds for abortion are not a satisfactory solution to the problem. "This procedure is objectionable," they state, "because there is no specification of psychiatric criteria to be used as guidelines..."

Summary

In summary, every psychiatric examination for therapeutic abortion should include not only an evaluation of present mental status, but also a prognostic evaluation of the post-abortion state of mind; i.e., are there psychiatric contraindications to the abortion? If there is any question about later sequellae or guilt causing depression, it may be necessary to recommend against the procedure on psychiatric grounds. Finally, evaluation for tubal ligation should be separate and include social, economic, and familial factors, as well as intrapsychic ones.□

Dr. Sadoff is clinical assistant professor of psychiatry at Temple School of Medicine and a lecturer in law at Temple University Health Sciences Center and at Temple Law School. Mr. Owens is a senior medical student at Temple University Medical School.

Fatal Pulmonary Hemorrhage Complicating Infectious Mononucleosis

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JEROME S. SIEGEL, MAJOR USAF MC
RALPH S. METHENY, JR., LT. COL. USAF MC

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Fatal pulmonary hemorrhage in a 23-year-old man with infectious mononucleosis is reported. His extensive hemorrhagic diasthesis resulted from profound hypersplenic thrombocytopenia which was a consequence of his underlying disease process.

INFECTIOUS mononucleosis is usually considered to be a benign disease. The reported fatality rates range from 0.5 per cent to 1.0 per cent.[1] The following case is presented to document a previously unreported but potentially fatal complication of this disease.

Report of a Case

A twenty-three year old caucasian man was admitted to an Air Force hospital on March 31, 1969, for evaluation of fever, malaise, anorexia,

lymphadenopathy, and tender hepatosplenomegaly. Ten days prior to admission he first noted malaise, shaking chills, fever, and night sweats. Five days prior to admission he was found to have *Streptococcus pyogenes* on throat culture, and was treated with oral penicillin. Despite treatment, he was admitted because of persistence of symptoms. See Table I for pertinent laboratory data.

Because of continued temperature elevation, progressive hepatic dysfunction, and deterioration in general clinical status, he received steroid therapy with oral prednisone for seven days. The patient's clinical condition and biochemical abnormalities improved markedly during this time and on April 22 he was discharged back to duty on no medication. Three days later he was readmitted to another hospital with recurrent malaise, chills, sore throat, and fever. He had no lymphadenopathy or hepatosplenomegaly. On the twenty-seventh hospital day of this second admission because of fever, jaundice, pancytopenia, and rapidly developing hepatosplenomegaly, he was transferred to a referral facility. His anemia, thrombocytopenia, hyperbilirubinemia and abnormal hepatic studies became more severe (Table I). A bone marrow examination demonstrated hyperplasia of myeloid, erythroid, and megakaryocytic elements (Figure 1). The direct and indirect Coombs tests were negative.

The patient's clinical condition deteriorated rapidly with the appearance of numerous petechiae and large ecchymoses. Additionally, extensive bleeding from his oral and nasal mucous membranes, gastrointestinal tract, and urinary tract occurred which necessitated numerous fresh whole blood transfusions.

On the thirty-third hospital day of this final admission the patient was started on dexamethasone intravenously. Splenectomy was not able to be performed because of his critical condition. On steroid therapy the patient showed symptomatic improvement, but his hematologic profile became worse. Then on the forty-fifth hospital day he developed dyspnea and suddenly expired.

At autopsy the liver weighed 3,600 grams. Microscopically there were circumscribed areas of necrosis involving an estimated 15 per cent of the liver tissue. In the necrotic areas were mononuclear cells including atypical lymphocytes.

The spleen weighed 1,250 grams and the intra-abdominal lymph nodes were slightly enlarged. Microscopically, the spleen and lymph nodes demonstrated necrotic changes which consisted of loss of normal architecture and diffuse infiltration by atypical lymphocytes (Figure 2). Atypical lymphocytes were also found interstitially in lung, myocardium, bone marrow, testes, and in a small accessory spleen. No intracellular microorganisms were found. The brain was not involved by hemorrhage or inflammation.

Both lungs exhibited extensive hemorrhage throughout. Microscopically, there was an irregular septal infiltration of mononuclear cells and scattered pink, amorphous material lining the alveoli. No viral inclusions were found. The immediate cause of death was attributed to respiratory failure secondary to massive pulmonary hemorrhage.

Comment

Infectious mononucleosis is almost universally considered a benign illness of little consequence. However, the literature is replete with reports of complications associated with this disease: neurologic sequelae, hepatitis, hepatic necrosis, splenic rupture, mesenteric adenitis, interstitial pneumonitis, erythematous eruption, dermatographia, myocarditis, pericarditis, conjunctivitis, mucosal hemorrhage, cerebral hemorrhage, hematuria, secondary infection both bacterial and viral, hemolytic anemia, granulocytopenia and thrombocytopenia.[1,2,3,4,5,6,7]

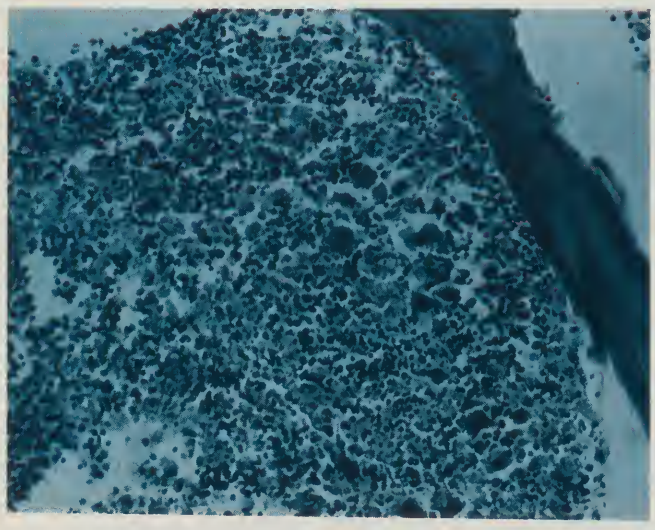

Figure 1: *Bone Marrow Examination at time of transfer to referral facility revealing panhyperplasia. x1000*

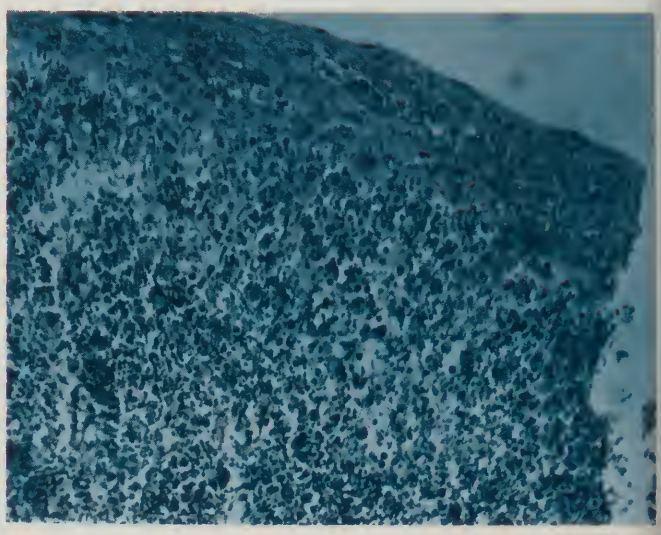

Figure 2: *Section of spleen at autopsy showing severe congestion, loss of follicular architecture, and mononuclear cell infiltration. x400*

TABLE 1
Laboratory Data

Date	*31 Mar*	*21 Apr*	*25 Apr*	*(on transfer) 21 May*	*7 June*
WBC (cells/mm³)	17,200	11,300	3,800	4,500	1,000
Lymphocytes (%)	65	79	70	53	
Atypical (%)	70	90	60	21	
Hematocrit (vol %)	39	38	34	27	24
Platelets (cells/mm³)			150,000	90,000	17,000
Heterophile Titer	1:728		1:112	1:7	
guinea pig absorption			1:56		
beef cell absorption			no titer		
Serum Bilirubin (mg/100 ml)					
direct	5.4	0.8	0.2	2.3	21.4
total	6.5	1.3	0.6	3.8	27.0
Alkaline Phosphatase (up to 57 international units normal)	112	43		62	91
SGOT (units)	575	34	70	138	78
SGPT (units)				185	145

A mild thrombocytopenia in infectious mononucleosis is not a rare finding. Aster[8] demonstrated a total normal platelet mass in one patient with infectious mononucleosis and further demonstrated in splenomegalic patients studied that 50 to 90 per cent of platelets are pooled at any given time in the spleen. Moreover, Cooney and Smith[9] suggested that hypersplenic thrombocytopenia appears to be the result of "a shift of platelets from the intravascular to the splenic pool" with the maintenance of a normal total platelet mass. However, platelet lifespan may be normal or even shortened; this would necessitate, respectively, a normal or increased platelet production. Rarely, blood volume expansion also may play a role in hypersplenic thrombocytopenia. Although the mechanism of thrombocytopenia in hypersplenism is multifold, it does not seem to be the result of suppressive thrombogenesis by the enlarged spleen.

Our patient manifested a prolonged clinical course and developed hypersplenism with progressive pancytopenia, severe hemolytic anemia, and hemorrhagic manifestations. He ultimately died of extensive pulmonary hemorrhage, a complication not previously reported in infectious mononucleosis. □

Dr. Timmons is a resident in internal medicine at Lankenau Hospital, Philadelphia. Dr. Siegel is in the private practice of internal medicine in Memphis, Tenn. Lt. Col. Metheny is presently stationed at Andrews Air Force Base Hospital. At the time the paper was prepared, all were associated with the departments of internal medicine and pathology, USAF Hospital, Tachikawa, Japan. *The authors wish to acknowledge the assistance of Dr. Barry Rosenbaum in the preparation of this paper.*

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A Stocking To Help Reduce Leg Phlebothrombosis In Bed Patients

BERNARD BERMAN, M.D.
Washington

THE ORIGIN of the thrombus in thrombo-embolism is much better understood than the pathogenesis. As Dexter has stated: "statistically and therapeutically the site of the origin should be considered to be the legs. The legs are commonly the site, the pelvis occasionally the origin, and the right side of the heart an unlikely source."

The important factors in the pathogenesis of the thrombi are accepted to be stasis, increased clotting, trauma and inflammation. The mortality rate of pulmonary embolism is about 20 per cent, and the recurrence rate is stated to be about 30 per cent.

If pressure on the soft tissues of the leg increase these risk factors, any attempt to reduce pressure on the superficial and deep veins should prove beneficial to the patient with this serious disease.

Studies in the Prevention of Leg Phlebothrombosis in Bed Patients Pressures Exerted on the Back of Leg

This study was undertaken in order to observe maximum pressure areas on the back of the leg. In addition, an attempt was made to correlate these areas of pressure and the more common sites of phlebothrombosis of the leg.

Method: Twenty-five bed patients, consisting of thin, medium, and obese body builds were selected from the general hospital population.

The dorsum of the lower legs and upper legs were coated with a homogeneous mixture of graphite granules and lanolin. The ointment was applied with tongue blade and two-inch brush to the back of leg while the leg was raised. The leg was then gently lowered on a pillow case, and an imprint of the back of the leg was obtained.

Results: In the thin patients, areas of greater pressure varied but tended to be located on or near the central portion of the lower leg.

In the patients of moderate build, the pressure areas appeared to be more diffuse, although there tended to be some pooling of the dye on the central portion of the lower leg.

The obese and very obese patients demonstrated a less consistent pattern. More pressure areas were present over the folds of fat where an imprint of the dye tended to be more diffuse. In this group more evidence of dye deposits were found on the lateral aspects of the leg, as well as the inner portion of the leg.

Use of Antipressure Stocking in an Attempt To Reduce Pressure on Popliteal and Tibial Vessels

An antipressure stocking, consisting of elastic legging, having a pair of pockets formed therein, was used in this study. The spaced pockets contain a cushioning material of foam rubber, and lie to either side of the popliteal vessels, reducing the pressure on the central part of the leg. In this manner pressure on the leg is, in general, better distributed, and in the central portion of the leg materially reduced.

Method: In twenty-five patients, pressures were recorded on the back of the lower leg. Two different systems were utilized: (1) A small bladder attached to a water manometer; and (2) closed air system using a small bladder attached to an aneroid manometer. Pressures were recorded placing the bladder under the dorsum of the leg under the mass of the gastrocnemius before and after the antipressure stocking was applied.

Results: In general, pressures on the dorsum of the lower leg averaged about 20 mm. After the antipressure stocking was applied, the pressure recordings generally fell to about 10 mm.

The air system, using a small bladder attached to an aneroid manometer, proved to be an easier and more satisfactory system to use for recording pressures.

Discussion: Measurements of pressure exerted by the leg in bed patients can only be approximate and subject to many variations, such as the firmness of the mattress, position and torsion on the bladder recording the pressure, relaxation of the patient, and a host of other variables. Estimation of pressure points of the leg are also subject to variations, such as position of the leg, amount of dye and manner of application of the dye. Despite the inherent deficiency of the method, in general, it might be stated that there is significant pressure on the dorsum of the leg often in the central portion, corresponding to the areas of frequent phlebothrombosis.

It has been demonstrated that the lower leg is the usual site of phlebothrombosis and thrombophlebitis. Most commonly involved are the deep veins of the calf, including the posterior tibial and popliteal. The superficial veins do not appear to be as serious a threat as a source of pulmonary emboli.

Since pulmonary embolism continues to be one of the most important causes of immediate death in the hospital population, further studies on the role of pressure in the genesis appear indicated.

It has been noted that since 1856, when Virchow suggested three possible causes of venous thrombosis, viz., stasis of blood, abnormality of the venous wall, and abnormal state of coagulation, little progress has been made in elucidating the fundamental causes of this disease. Localized areas of increased soft tissue pressure, in localized areas of the dorsum of the leg would appear to be important in the first two causes, but its overall significance has not been fully studied.

An antipressure stocking containing pockets of cushioning material which lie on either side of the popliteal vessels is described. The pressure on the central portion of the leg is reduced, and the pressure from the weight of the extremity is more evenly distributed.

The stocking is now being given a trial usage in patients, and appears to be well tolerated. Inasmuch as the stocking has the effect of elevating the heel from the bed, it is hoped that the device will act to reduce decubitus heel ulcers.

Summary

1. A new antipressure elastic stocking to assist in the prevention of phlebothrombosis in bedridden patients is described.
2. The stocking reduces, materially, the pressure exerted on the back of the leg, the most frequent sites of occurrence of phlebothrombosis and also reduces pressure on the heel.
3. The stocking is currently being given a trial. It is comfortable and well tolerated by the patients. It is anticipated that following a suitable clinical trial the device will prove effective in reducing the incidence of pulmonary embolism.

Addendum

Since this manuscript was submitted, 200 bed patients (cardiac, orthopedic, urologic, gynecologic and general surgical) have used the stocking. The stocking has been well tolerated and no cases of leg phlebothrombosis have occurred in this group. □

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PENNSYLVANIA MEDICINE cardiovascular brief

Current Status of Rheumatic Fever Part II

C. Robert E. Wells, M.D., professor of pediatrics, Temple Medical School, Philadelphia, is questioned by William G. Leaman, Jr., M.D.

Is rheumatic fever inherited?

No, but individuals in certain families have a greater tendency to develop rheumatic fever following an untreated streptococcal infection than do individuals in other families. If both parents had rheumatic fever, their children would have a greater tendency to develop rheumatic fever than children whose parents did not have the disease.

Is there a specific treatment for rheumatic fever and rheumatic heart disease?

No. Except for the treatment of the streptococcal infection with *penicillin*, the treatment is symptomatic. *Rest* during the active infection reduces the work of the heart. *Salicylates* promptly relieve the pain and are somewhat anti-inflammatory. *Steroids* are anti-inflammatory and may even be life-saving in the presence of severe carditis. There is still considerable controversy whether early treatment with steroids can minimize or prevent carditis. There are many other measures involving the art of medical practice which are necessary and helpful in management during the acute and convalescent phases of a sometimes protracted illness.

Can rheumatic fever be prevented?

Yes. Prompt and adequate treatment within three days of onset of a Group A beta hemolytic streptococcal infection should prevent the majority of complications (rheumatic fever, nephritis). Recommended treatment: (a) 600,000 to 1.2 million Units benzathine penicillin G intramuscularly, or (b) 200,000 to 250,000 Units penicillin G orally three or four times a day for ten days, or (c) 250 mgm. Erythromycin orally three or four times a day for ten days if the patient is allergic to penicillin. It is well known that clinically unrecognized streptococcal infections do occur which are untreated and which may be followed by rheumatic fever.

Can recurrence of rheumatic fever be prevented?

Yes. (a) The preferred method is monthly injections of 1.2 million Units of benzathine penicillin G. (One is certain of the prophylaxis being given, but the injection is uncomfortable and the incidence of penicillin sensitivity is higher than with oral penicillin). (b) 400,000 Units Penicillin G orally once daily. (This requires cooperation of patients. Failures are often associated with irregular prophylaxis). (c) 0.5 Gm. sulfadiazine orally once daily for patients under 60 pounds or 1.0 Gm. if over 60 pounds. (Problem of cooperation same as with penicillin). Sulfadiazine is an effective prophylactic agent but should not be used in treatment of streptococcal infections. It is bacteriostatic while penicillin is bacteriocidal.

If penicillin prophylaxis is given daily, won't its effectiveness decrease in time?

No. Despite the use of penicillin for about twenty-five years, the streptococcus is still just as sensitive to penicillin as it was in the beginning.

Isn't daily penicillin prophylaxis expensive?

Not excessive. Physicians can furnish low-cost penicillin for about $15 a year. Some local heart associations and some health departments furnish penicillin free to registered rheumatic fever patients.

What is the role of the practitioner in the prevention, diagnosis and management of rheumatic fever?

(a) *Recognize streptococcal infections* clinically and by culture. Many clinicians have small incubators in their offices. A simple technic and instructions for culturing are available through local heart associations, some of whom sponsor a low-cost culture program in a local hospital laboratory. (b) *Treat* promptly and adequately. (c) *Avoid overdiagnosis* by recognizing that "growing pains" are not migratory polyarthritis; that an innocent murmur is not an organic murmur; and that *the diagnosis must be made clinically* and not in the laboratory. If in doubt, a consultation with one experienced in evaluating children's hearts would be in order. (d) *Prevent recurrences* in patients who have had rheumatic fever or rheumatic heart disease. Daily prophylaxis should be continued indefinitely. (e) *Employ prophylaxis against subacute bacterial endocarditis* for any patient with rheumatic or congenital heart disease who needs surgery in a potentially infected area (dental extraction, tonsillectomy). This is done as follows: 600,000 Units crystalline and 600,000 Units procaine penicillin intramuscularly one to two hours before surgery; then 500,000 Units Penicillin G orally four times a day for three days after surgery. For patients on continuous oral penicillin prophylaxis, Erythromycin is recommended in the dose of 500 mgm. two hours before surgery, to be followed by 250 mgm. Erythromycin four times a day for three days.

William G. Leaman, Jr., M.D. edited this Brief for the Council on with the Pennsylvania Heart Association.

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Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication – Demulen is indicated for oral contraception.

Contraindications – Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings – The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association. between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain [1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users were several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions – The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives – A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted; anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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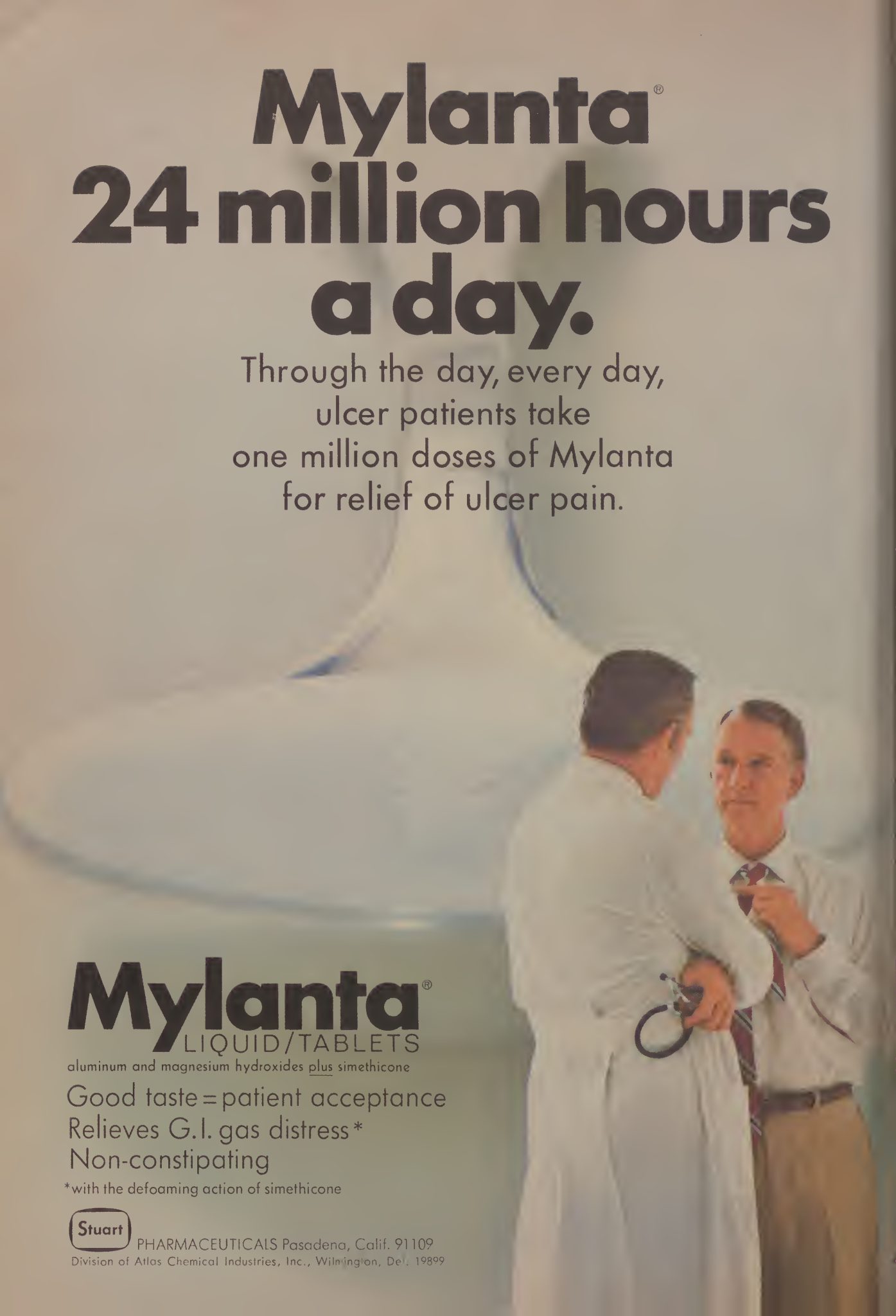

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Surgical and Radio-Iodine Therapy in Thyroid Carcinoma

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and

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IN the past two decades the diagnosis of thyroid carcinoma has been facilitated by new techniques. Thyroid scanning with 131-I Sodium Iodide offers pre-operative information which has assisted in the selection of patients for surgery. New scanning techniques using ^{131}Cesium[1] and ^{75}Selenomethionine[2] have been suggested for improvement of pre-operative diagnosis and selection.

During this period also, the role of Radio-Iodine in the therapy of thyroid carcinoma has been more clearly defined as an adjunct to surgery.[3]

This paper reviews all patients with thyroid carcinoma who received initial or continuing treatment at the Harrisburg Hospital during the decade 1960 to 1970.

There are forty-three such patients. They are classified into three groups according to the treatment received, surgery only (Group I); surgical failure and 131-I (Group II); and surgery and 131-I (Group III). The surgical failure and 131-I group includes all patients who following initial definitive surgical therapy had a local recurrence or

TABLE I

Thyroid Cancer

Group I — (Surgery Only)

Patient	Sex	Age	Cell Type	Extent At Diagnosis	Surgery	Post. Op. Survival Years	Result*	A/D[1]
R.M.	M	39	Papillary	Local	Hemi.	2	G	A
P.S.	M	56	Papillary	Local	Hemi.	9 & 6/12	G	A
A.H.	F	45	Papillary	Local	Hemi.	8	G	A
B.C.	F	34	Papillary	Cervical	Hemi.	7 & 6/12	G	A
E.M.	M	44	Papillary	Local	Hemi.	7	G	A
G.C.	F	22	Papillary	Cervical	Hemi.	7	G	A
N.T.	F	43	Papillary	Local	Hemi.	2 & 6/12	G	A
M.P.	F	38	Papillary	Local	Hemi.	7	G	A
A.B.	F	36	Papillary	Local	Hemi.	3	G	A
S.G.	F	56	Mixed	Local	Total	5	G	A
M.H.	F	33	Follicular	Local	Hemi.	2 & 9/12	G	D
J.Y.	F	50	Papillary	Local	Hemi.	10	P	A
M.D.	F	82	Solid	Cervical	Total	?	P	
I.K.	F	82	Anaplastic	Distant	Hemi.	within 6/12	P	D
A.S.	F	63	Papillary	Distant	Biopsy	1	P	D
M.S.	F	66	Mixed	Distant	Biopsy	3/12	P	D
D.J.	F	72	Undifferent.	Distant	Biopsy	2/365	P	D
C.W.	F	51	Papillary	Local	Hemi.	N	N	N
O.B.	F	63	Hurthle	Local	Hemi.	N	N	N
R.S.	F	59	Anaplastic	Local	Biopsy	N	N	N

G = Good
P = Poor
N = No Follow Up

[1] A = Alive
D = Dead

a distant metastasis and were then referred for Radio-Iodine therapy. These groups were further subdivided according to the patient's current condition:

1. Living and free of disease, (good), or
2. Dead due to disease or alive with recurrence or spread of disease (poor).

All patients were further categorized according to sex, age, cell type, extent of disease at initial diagnosis and at time of Radio-Iodine therapy.

This latter was defined as:

a) Localized (thyroid gland only)
b) Cervical extension
c) Distant metastases (extra cervical sites).

The surgical procedures were recorded as biopsy, hemithyroidectomy, and total thyroidectomy. For purposes of this paper a total thyroidectomy was defined as a small contralateral remnant remaining in order to preserve the parathyroid glands. Additional observations included 131-I uptake before Radio-Iodine therapy, initial 131-I treatment dose, total 131-I treatment dose, length of survival and replacement therapy administered. These data are summarized in Tables I, II, and III.

Results

Of the forty-three patients, twenty were treated by surgery alone (Group I). There were eleven surgical failures who were referred for 131-I therapy (Group II). Twelve other patients received combined surgery and 131-I treatment. These were not surgical failures. In general, this represented the initial plan of therapy (group III).

Mortality and Morbidity

Of the twenty patients treated with surgery only (Group I) there is no follow-up in three. Eleven are alive and free of evidence of disease (65 per cent). Six died or showed evidence of recurrence or spread of their disease. (See Table I)

Eleven patients developed local recurrence or distant metastasis after initial surgical therapy (Group II) and were referred for Radio-Iodine therapy. In one patient there is an insufficient follow-up. Three have had a good result (30 per cent), seven have had a poor result (See table II).

Twelve patients received a combination of surgery and Radio-Iodine therapy (Group III). In two patients the duration of follow-up is too short (less than three months) for purposes of evaluation. Eight are alive and free of disease (80 per cent); two have died as a consequence of their disease (See Table III).

Age & Sex

Table IV compares the characteristics of each group according to result of therapy. There are more females in each group except Group II, patients with a poor result.

The ages of diagnosis ranged from thirteen to eighty-five years. There were no patients forty-five years or younger who had a poor result. Of twenty-two patients with a good result,

TABLE II

Thyroid Cancer

Group II — (Surgical Failure & ^{131}I)

Patient	Sex	Age	Cell Type	Extent At Diagnosis	Surgery	Post. Op. Survival	Interval S-^{131}I Years	Extent At 131-I	Pre-^{131}I Treatment Uptake %	Initial Dose(mCi)	Total Dose (mCi)	Post^{131}I Survival Years	Result*	A/D[1]
1-1 F.W.	M	53	Mixed	Cervical	Hemi.	12 & 5/12	11 & 1/12	Distant	2	50	50	1 & 4/12	P	D
1-2 M.T.	F	27	Follicular	Cervical	Hemi.	17 & 1/12	10 & 2/12	Cervical	27	50	50	7	G	A
1-5 R.H.	M	60	Medullary	Cervical	Hemi.	5 & 10/12	3 & 5/12	Distant	4	50	50	2 & 5/12	P	D
1-7 P.K.	F	50	Follicular	Cervical	Hemi.	4 & 10/12	2 & 6/12	Distant	25	50	426	2 & 7/12	P	D
I-20 W.I.	M	22	Papillary & Solid	Cervical	Total	7 & 1/12	8/12	Cervical	9	50	100	6 & 5/12	G	A
I-95 C.S.	F	47	Mixed	Cervical	Hemi.	3 & 11/12	2	Distant	10	150	781	1 & 11/12	P	D
I-208 H.G.	M	50	Follicular	Localized	Hemi.	12 & 6/12	9 & 1/12	Distant	1	100	800	3 & 5/12	P	A
I-511 J.H.	F	24	Papillary	Localized	Hemi.	4 & 4/12	2 & 6/12	Cervical	1	50	100	1 & 10/12	G	A
I-949 W.W.	M	66	Papillary	Cervical	Hemi.	2 & 1/12	1 & 6/12	Cervical	40	100	100	7/12	P	D
I-1145 G.G.	M	51	Solid	Cervical	Hemi.	2 & 2/12	5/12	Cervical	—	50	100	1 & 9/12	P	A
I-2508 P.C.	M	30	Follicular	Localized	Total	2 & 5/12	2 & 4/12	Cervical	8	46	46	1/12	IN	A

*G=Good
P=Poor
IN=Insufficient F.U.

[1]A=Alive
D=Dead

TABLE III
Thyroid Cancer

Group III — (Combined Therapy)

ıtient	Sex	Age	Cell Type	Extent At Diagnosis	Surgery	Post Op. Survival Years	Interval S-^{131}I Years	Extent At 131-I	Pre-^{131}I Treatment Uptake %	Initial Dose (mCi)	Total Dose (mCi)	Post^{131}I Survival Years	Result*	A/D[1]
1-3														
.S.	M	49	Mixed	Local	Total	6 & 9/12	1/12	Local	6	50	50	6 & 8/12	G	A
1-4														
.M.	M	13	Mixed	Local	Total	12 & 9/12	8/12	Local	18	171	171	12 & 1/12	G	A
-70														
.B.	F	73	Hurthle	Distant	Biopsy	2/52	2/52	Distant	11	50	50	2/52	P	D
-97														
.P.	F	29	Follicular	Cervical	Total	12 & 10/12	5/12	Cervical	14	110	210	12 & 5/12	G	A
-100														
.N.	F	43	Anaplastic	Cervical	Hemi.	9 & 7/12	4 & 5/12	Cervical	42	50	50	5 & 2/12	G	A
-236														
.F.	F	73	Papillary	Localized	Total	4 & 9/12	——	Local	—	50	50	5 & 3/12	G	A
-308														
.H.	M	65	Follicular	Localized	Hemi.	4 & 3/12	7/12	Local	11	50	100	3 & 8/12	G	D
-502														
.F.	F	25	Papillary	Cervical	Total	4 & 5/12	1/12	Cervical	—	50	150	4 & 4/12	G	A
1143														
.E.	F	85	Mixed	Local	Total	3	2/52	Local	2	46	46	2 & 11/12	P	A
1727														
.H.	F	25	Papillary	Not Known	Hemi.	6 & 3/12	6 & 1/12	Not Known	1	55	55	2/12	IN	A
2063														
R.S.	F	37	Medullary	Local	Total	5/12	1/12	Local	4	50	50	4/12	G	A
2138														
M.V.	F	49	Follicular	Local	Total	10/12	9/12	Local	1	50	50	1/12	IN	A

G=Good
P=Poor
N=Insufficient F.U.

[1]A=Alive
D=Dead

seventeen (77 per cent) were forty-five years or less.

Cell Types

The cell type of the tumors indicates that twelve patients with good results had primarily papillary tumors. In twenty patients (91 per cent) with good results, papillary, follicular, or mixed tumors were found. Among the patients with a poor result there were three papillary tumors. Nine (60 per cent) patients had papillary, follicular, or mixed tumors.

Extent of Disease

At the time of initial diagnosis (Table IV) eighteen patients had localized disease, fifteen of whom ultimately had a good result. Fourteen had cervical extension, seven of whom ultimately had a good result. Five had distant metastases, none of whom had a good result.

In Group I, twelve patients had hemithyroidectomies, two had total thyroidectomies. In three patients only a biopsy was performed. In Group III, seven total thyroidectomies were performed (78 per cent). In one of these, a poor result occurred.

131-I uptake studies before Radio-Iodine therapy (twenty patients) are recorded in tables II and III and show considerable variation. The uptake was less than 10 per cent (hypothyroid range) in ten patients (50 per cent). Initial therapy varied from 46 to 171 mCi. The total 131-I treatment dose ranged from 46 to 800 mCi.

Survival

Survival records are available for thirty-six patients. Follow-up in Group I patients was accomplished by discussions with the operating surgeon or referring physician. All other patients are followed in the section of nuclear medicine by one of us (GLJ). The duration ranges from two weeks to seventeen years. Figure I illustrates this and compares mean and median survival for each of the three groups as well as subgroups of Groups II & III.

Survival was also studied according to the following characteristics: sex, age, cell type of tumor, distribution of disease, operative procedure. A correction has been calculated for patients who had only a biopsy (inadequate therapy) and those who died from unrelated causes. These patients were deleted in corrected figures. (See Table V)

Thyroid Replacement Therapy

Records of thyroid replacement therapy in the surgically treated group are not available. In Group II, seven of ten patients received no thyroid replacement therapy for variable intervals (2/12; 5/12; 2, 2 9/12, 4 1/12, 11 1/12 years). Of the ten patients in

Group III, three received no thyroid replacement therapy. The intervals were 5/12, 7/12, and 4 5/12 years. Two patients received Propylthiouracil during this period to increase the uptake of Radio-Iodine. All patients in Groups II & III are now receiving thyroid replacement therapy (principally T-3 (L-tri-iodo-thyronine); some T-4 (L-thyroxine); or a combination).

Discussion

As this evaluation proceeded, it became obvious that patients who received both surgery and Radio-Iodine therapy fell into two groups. Those patients who were referred for Radio-Iodine therapy after initial surgery because of the development of a local recurrence or distant metastasis should be reported separately. Indeed, there is reason to report them (surgical failures) with the surgical results (Group I). If this were done, sixteen of twenty-seven patients initially treated surgically had poor results (59 per cent). Of these sixteen patients, ten were referred for Radio-Iodine treatment.

There is a preponderance of females in both groups (Group I, 82 per cent; Group III, 70 per cent). Study of age distribution reveals 53 per cent (9/17) in Group I and 50 per cent (5/10) in Group III were forty-five years or less. It is known that young patients and females with thyroid carcinoma have a better outcome than others.[4]

The cell type shows a dissimilar distribution (Groups I & II). Fifty-three per cent of the patients in Group I and 20 per cent of those in Group III had papillary tumors. Papillary tumors in general, are thought to be associated with improved prognosis.[5]

Ten (59 per cent) patients in Group I and six (60 per cent) of those in Group III had localized disease. Tumors localized to the thyroid have a better prognosis.[4,6]

The surgical procedures utilized in the two groups were different. Twelve (71 per cent) patients in Group I had hemi-thyroidectomies. Seven (70 per cent) in Group III combination therapy had total thyroidectomies.

The overall results indicate:

30 per cent good results in Group II
65 per cent good results in Group I
88 per cent good results in Group III

Comparing the duration of survival (figure I) it should be noted that both the median years and the mean years of post-operative survival for the surgical failure group exceed the same figures for the Group I patients. This suggests that if a sufficiently long period of time elapses after operation, an increased likelihood of recurrence or spread occurs.

Figure II is a graphic presentation of survival using the data tabulated in Table VI. This indicates persons dead and alive at six month intervals for the three groups. Survival was calculated as follows:

$$\frac{A}{N + A} \times 100 = \text{percentage of survival}$$

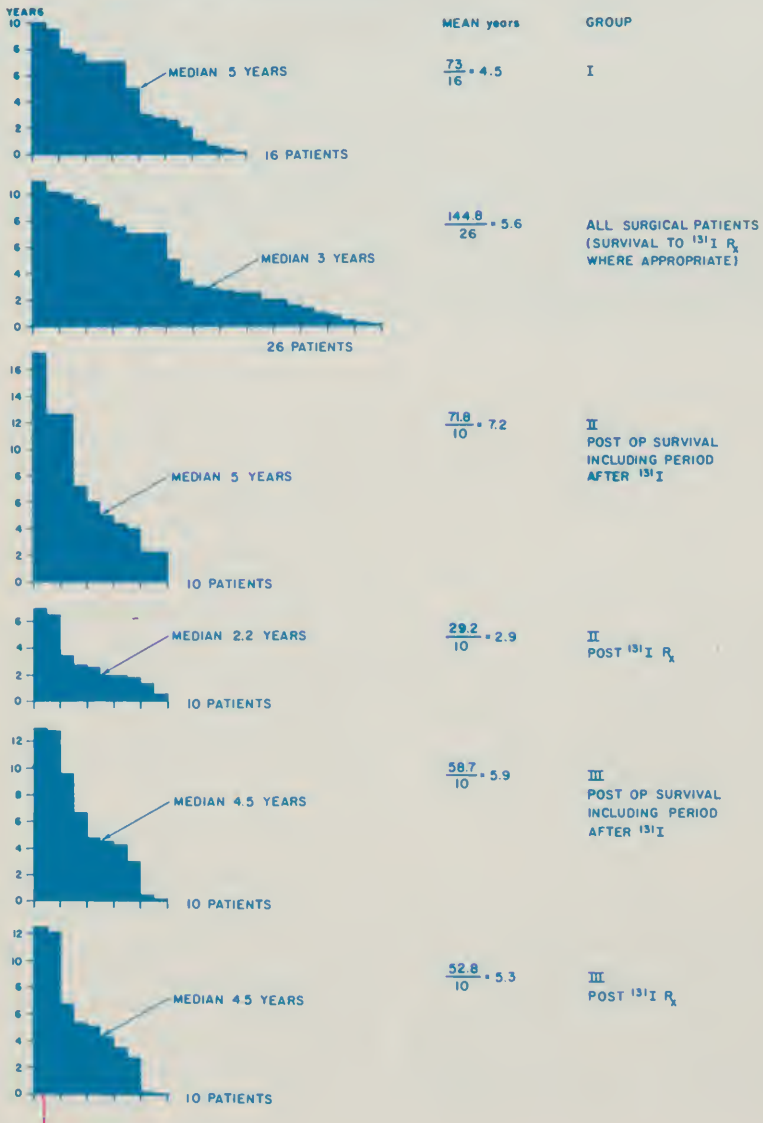
where N = cumulative number of dead to any time (t); A = number of patients alive at t.

Figure II does not permit broad generalizations. There may be a difference of survival between Group I and the others beginning at the sixth year of observation.

A review of Table V indicates that Group III survival is equal to or better than that for the other groups, except for the male and hemi-thyroidectomy subgroups. Correlation (elimination of inadequate therapies and unrelated deaths) indicates Group III survival is regularly as good as or better than that of all other groups.

The course of thyroid carcinoma is notoriously variable, even if untreated. Thus, any attempt to evaluate the

Figure I THYROID CANCER – SURVIVAL



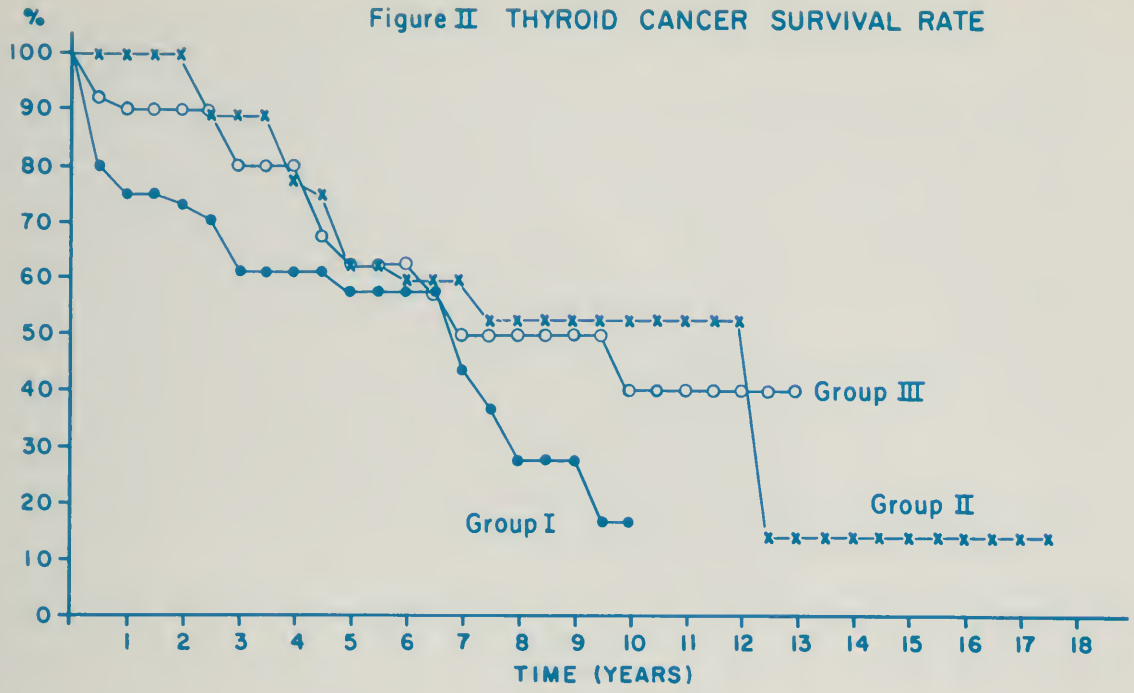


Figure II THYROID CANCER SURVIVAL RATE

results of therapy becomes exceedingly difficult unless a very large series of patients can be studied. A recent report from the University of Michigan Medical Center[7] indicates that, in a series of 283 patients with thyroid carcinoma, a significant improvement in prognosis occurred with the addition of Radio-Iodine to the treatment program. Fifty-nine per cent of surgically treated patients died compared to 18 per cent for those threated with surgery and 131-I. Halman[6] has reported that the three significant features determining prognosis in their series were: (1) Age. The younger the patient the better the prognosis. (2) Metastases. The five-year survival in patients with distant metastases is 30 per cent compared to 80 per cent in patients with localized disease. At ten years comparable figures are 15 per cent and 80 per cent. (3) Extent of initial surgery. Complete surgical excision is the best form of treatment.

A recent summary of the M.D. Anderson Hospital experience[8] indicates that in thirty-four patients elected for total thyroidectomy for carcinoma, twenty-one had cancer in the presumed normal contralateral lobe. In eighty-two sub-total thyroidectomies twenty patients subsequently were discovered to have cancer in the contralateral lobe at the time of delayed excision.

Silverberg, et. al.[4] also have stressed the tendency of differentiated thyroid cancer to develop anaplastic features years later.

Further justification for total thyroidectomy is succinctly presented in the following quotation from Carroll.[9] "The absolute minimal surgical procedure is unilateral thyroid lobectomy. Because these primary lesions are definitely invasive, the involved lobe must be removed as thoroughly as possible. Contralateral involvement in the opposite lobe can be demonstrated microscopically in as many as 30 per cent of these patients. In addition, there is always the likelihood of future necessity for the use of radioactive iodine in some of these patients. For these reasons, there is considerable justification in removing as much of the contralateral lobe as is compatible with the safety of the opposite pair of parathyroid glands, as well as the contralateral recurrent laryngeal nerve. Although total thyroidectomy has been occasionally advocated, this rarely seems to be practical because of the distressing incidence of post-operative hypo-parathyroidism. By preservation of a small sliver of thyroid tissue, simultaneous preservation of the contralateral parathyroids is usually assured. At a later time, this residue of thyroid tissue can be defunctionalized by the administration of a small amount of radioactive iodine if desired."

Radio-Iodine therapy for recurrent or metastatic disease in the patients initially treated by hemi-thyroidectomy is delayed at best and occasionally complicated as a result of the surgery.

We recommend the following general therapeutic outline for thyroid carcinoma:

1. Total thyroidectomy (with preservation of contralateral parathyroid glands).

2. Post-operative uptake and scan

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TABLE IV
Results of Therapy - A Comparison

GOOD RESULTS GROUP I	GOOD RESULTS GROUP II	GOOD RESULTS GROUP III	FEATURE	POOR RESULTS GROUP I	POOR RESULTS GROUP II	POOR RESULTS GROUP III
3	1	3	Male	0	5	0
8	2	5	Female	6	2	2
9	3	5	45 years or less in age	0	0	0
2	0	3	>45 years of age	6	7	2
9	1	2	Papillary Ca.	2	1	0
1	1	2	Follicular Ca.	0	2	0
1	1	2	Mixed Ca.	1	2	1
0	0	1	Solid Ca.	1	2	0
0	0	0	Hurthle Cell Ca.	0	0	1
0	0	1	Anaplastic Ca.	1	0	0
0	0	0	Undifferentiated Ca.	1	0	0
9	1	5	Surg. Local disease at Surg.	1	1	1
—	0	5	131-I Local disease at 131-I	—	0	1
2	2	3	Surg. Cervical disease at Surg.	1	6	0
—	3	3	131-I Cervical disease at 131-I	—	2	0
0	0	0	Surg. Distant disease at Surg.	4	0	1
—	0	0	131-I Distant disease at 131-I	—	5	1
10	2	2	Hemithyroidectomy	2	7	0
1	1	6	Total Thyroidectomy	1	0	1
0	0	0	Biopsy	3	0	1

TABLE V

FEATURE	GROUP I		GROUP II		GROUP III		Survival I	Survival II	Survival III
	A*[1]	D*[2]	A	D	A	D	%	%	%
Male	3	0	4	3	2	1	100	57	67 100*[4]
Female	8	5	2	2	8	1	62 89*[4]	50	89 100*[4]
10-19 yrs.	-	-	-	-	1	-	—	—	100
20-29 yrs.	1	-	3	-	3	-	100	100	100
30-39 yrs.	4	1*[3]	1	-	1	-	80 100*[4]	100	100
40-49 yrs.	3	-	-	1	3	-	100	0	100
50-59 yrs.	3	-	2	2	-	-	100	50	—
60-69 yrs.	-	2	-	2	-	1*[3]	0 100*[4]	0	0 100*[4]
70-79 yrs.	-	1	-	-	1	1	0 100*[4]	—	50 100*[4]
80-89 yrs.	-	1	-	-	1	-	0		100
<40 yrs.	5	1*[3]	4	-	5	-	83 100*[4]	100	100
> 40 yrs.	6	4	2	5	5	2*[3]	60 75*[4]	29	71 100*[4]
Papillary	10	1	1	1	3	-	91 100*[4]	50	100
Follicular	-	1*[3]	3	1	2	1*[3]	0 100*[4]	75	67 100*[4]
Other Cell Types	1	3	2	3	5	1	25 50*[4]	40	83 100*[4]
Localized	9	1*[3]	3	-	6	1*	90 100*[4]	100	86 100*[4]
Cervical	2	-	3	5	3	-	100	38	100
Distant	-	4	-	-	-	1	0 0*[4]	—	0 100*[4]
Total Thy. X	1	-	2	-	8	-	100	100	100
Hem. Thy. X	10	2*[3]	4	5	2	1*[3]	83 91*[4]	44	67 100*[4]
Biopsy	-	3	-	-	-	1	0	—	0

*1 [1]A = Alive *3 = Died not due to thyroid Ca.
*2 [2]D = Dead *4 = Corrected rate (see text)

TABLE VI

Yrs.	Group I		Group II		Group III	
	Dead	Alive	Dead	Alive	Dead	Alive
½	3	13	0	11	1	11
1	3	12	0	11	1	10
1½	4	12	0	11	1	9
2	4	12	0	11	1	9
2½	4	11	1	8	1	9
3	4	10	1	8	2	8
3½	5	8	1	8	2	8
4		8	1	8	2	8
4½		8	2	6	3	8
5		8	2	6		6
5½		7	3	5		5
6		7	4	4		5
6½		7	4	4		5
7		7	4	4		4
7½		4	4	3		3
8		3	4	3		3
8½		2	4	3		3
9		2	4	3		3
9½		1	4	3		3
10		1	4	3		3
10½		1	4	3		2
11			4	3		2
11½			4	3		2
12			4	3		2
12½			5	2		2
13				1		
13½				1		
14				1		
14½				1		
15				1		
15½				1		
16				1		
16½				1		
17				1		
17½				1		

with 1 mCi. Radio-Iodine.

3. Administration of 50 mCi. 131-I Sodium Iodide if the scan reveals residual accumulation in the neck. Recent discussion of the use of diuretics to augment 131-I uptake in thyroid carcinoma patients has been presented and may be considered if the uptake is low.[10]

4. Repeat sequence two and three every three months until no Radio-Iodine accumulation is observed.

5. Thyroid replacement therapy.

Summary

This is a review of all patients who received initial or continuing therapy for thyroid carcinoma at the Harrisburg Hospital during the decade 1960-1970. This suggests that young female patients with papillary tumors localized to the thyroid gland have a better outcome than others. This suggests also, that the inclusion of Radio-Iodine in initial therapy improves prognosis and survival. A suggested program of therapy is outlined. □

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WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

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Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

Each capsule contains 300 mg of methyprylon.

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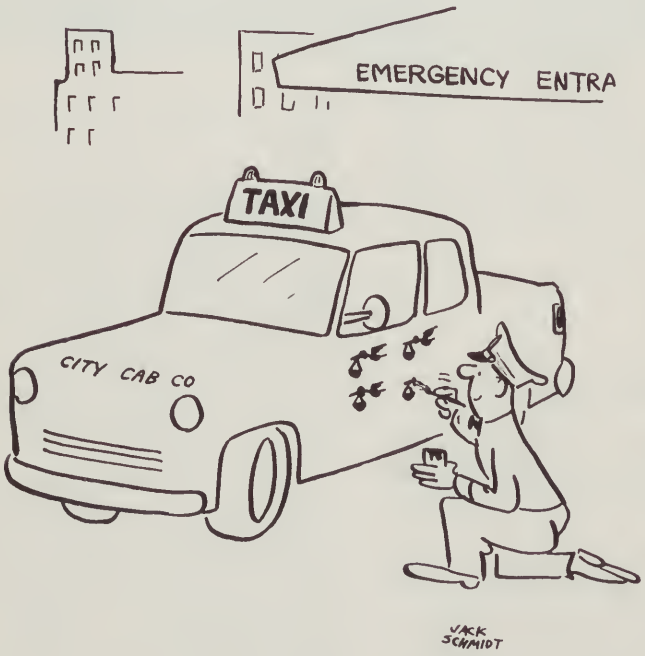

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Your ulcer patients and others will confirm it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

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INTERMITTENT COURSES

Listed below are courses of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, contact the director at the address given in the course listing.

CODE KEY

C—Consecutive days
I—Intermittent
O—Circuit
PG—Postgraduate Traineeship
S—Designed for full-time specialists
AMA—AMA Accredited Institution
CES—Council on Education and Science, Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
Hershey—Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Pitt—University of Pittsburgh, School of Medicine
Penn State—Pennsylvania State University
Temple—Temple University Health Sciences Center
U. of Pa.—University of Pennsylvania, School of Medicine
Woman's—The Medical College of Pennsylvania

GASTROENTEROLOGY

Philadelphia; January 14—April 18, 1971

I/AMA—SYSTEMATIC REVIEW OF GASTROENTEROLOGY; by U. of Pa.; at Lecture Room A; 4 hrs. ea. day; 1 day ea. week; 8 weeks; 32 hrs. AAGP credit requested; $150 fee. Contact Aaron D. Freedman, M.D., Assoc. Dean, U. of Pa., 288 Med. Labs. Bldg., Philadelphia 19104.

GENERAL MEDICINE

Aliquippa-Rochester Hosps. (rotation); third Wed., ea. mo.

Altoona Hospital; fourth Thurs. ea. mo.

Greensburg (Westmoreland Hosp.); first Tues. ea. mo.

Johnstown (Conemaugh Valley Mem. Hosp.); first Thurs., ea. mo.

Natrona Heights (Allegheny Valley Hosp.); second Tues. ea. mo.

Uniontown Hospital; last Mon. ea. mo.

Washington Hospital; first Wed. ea. mo.

O/I—DIAGNOSIS AND MANAGEMENT OF HYPERTENSION; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin P. Shapiro, M.D., Project Dir., 501 Flannery Bldg., 3530 Forbes Ave., Pittsburgh 15213.

Altoona Hospital; October 15, 1970—May 20, 1971

I—AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every other Thurs.; 7 months; 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 17, 1970—May 20, 1971

I—AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Luke's Hosp.; third Thurs. ea. mo. (except December); 8 mos.; AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford/Kane; October 20, 1970—May 18, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; alternately at Bradford's Penn Hills Club and Kane Manor; third Tues. ea. mo., 18 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Chester; September 8, 1970—May 25, 1971

I/AMA — POSTGRADUATE SEMINARS FOR PHYSICIANS: BY Hahnemann; at Crozer-Chester Med. Center; 2 hrs. AAGP credit approved ea. day; 38 days; a day ea. week. Contact James E. Clark, M.D., Chief of Med., Crozer-Chester Med. Center, 15th & Upland Sts., Upland, Chester 19013.

Erie; September 17-18, 1970—May 13-14, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at St. Vincent's Hosp.; Thurs. eve. and Fri. morn.; approx. once every three weeks; 39 hrs. AAGP credit applied for. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Harrisburg; November 10, 1970—May 11, 1971

I/AMA—CONTINUING EDUCATION COURSE; by Hahnemann; at Harrisburg Polyclinic Hospital; once ea. month. Contact David A. Smith, M.D., D.M.E., Harrisburg Polyclinic Hosp., Harrisburg 17105.

Hazleton State Gen. Hosp.; September 2, 1970—May 26, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hazelton Branch of Luzerne Co. Med. Soc., and Hosp.; 1½ hrs. per day; 1 day per week; 36 weeks; 30 hrs. AAGP credit. Contact Robert L. Gunderson, M.D., Dir. of Med. Educ., Hazelton State Gen. Hosp., Hazelton, Pa. 18201.

Johnstown; November 24, 1970—May 25, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Conemaugh Valley Memorial Hosp., fourth Tues. ea. mo. (except Jan.); 6 sessions, 2 hrs. ea.; 12 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lancaster General Hosp.; September 22, 1970—May 18, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; 1 day ea. week; 18 weeks; 3 hrs. AAGP credit applied for ea. session. Contact John H. Esbenshade, Jr., M.D., Dir. of Medical Educ., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17601.

Philadelphia; September 14, 1970—May 17, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Methodist Hosp.; first and third Mon. ea. mo. (except holidays); AAGP approval requested. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Pottsville; September 24, 1970—May 27, 1971

I/AMA—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann; at Good Samaritan Hosp.; fourth Thurs. ea. mo. (except Nov., Dec. and Apr.); 2 hrs. ea. day. Contact Norman M. Wall, M.D., Dir. of Med. Educ., Good Samaritan Hosp., E. Norwegian and Tremont Sts., Pottsville 17901.

Pottsville Hospital; September 3, 1970—June 3, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; first Thurs. ea. mo.; 10 mos.; 2 hrs. AAGP credit approved per session. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

Pottsville Hospital; First Thurs. of every mo., beginning September, 1971

I—CONTINUING MEDICAL EDUCATION; by Pottsville Hospital; 2 hrs. ea. day; 1 day ea. mo.; 20 hrs. AAGP credit requested. Contact E. W. Cubler, M.D., D.M.E., Pottsville Hospital, Mauch Chunk & Jackson Sts., Pottsville 17901.

Reading: September 22, 1970—May 25, 1971

I—1970-71 CONTINUING EDUCATION PROGRAM; at St. Joseph's Hosp.; fourth Tues. ea. mo. (except December); 8 hrs. AAGP credit requested. Contact Kenneth M. Schreck, M.D., Med. Dir., St. Joseph's Hosp., 215 Walnut St., Reading 19603.

Sayre: August 24, 1970—June 14, 1971

I—ROTATING SEMINARS (10 sessions Cardiology; 5 sessions Dermatology; 11 sessions Endocrinology; 13 sessions Hematology; 7 sessions Neurology; 8 sessions Psychiatry; 4 sessions Radiation Therapy; 9 sessions Urology—Nephrology); at Robert Packer Hosp.; 1 hr. ea. session; hour-for-hour AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., Dir. Med. Educ., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Scranton; October 21, 1970—May 19, 1971

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; at Mercy Hosp.; 1 day a month; 8 months; 24 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Sellersville; September 23, 1970—June 16, 1971

I—CONTINUING MEDICAL EDUCATION PROGRAM; by Hahnemann and Grandview Hosp.; at Grandview Hosp.; fourth Wed. ea. mo. (except December); 18 hrs. AAGP credit requested. Contact D. Henry Ruth, M.D., Dir. of Med. Educ., Grandview Hosp., Sellersville 18960.

Somerset Community Hospital; October 14, 1970—May 12, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (A Pennsylvania Medical Continuing Education Program); by CES; second Wed. ea. mo. except Jan. & Feb.; 18 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Somerset Community Hospital; Fourth Tues. of ea. mo.

I — A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Western Pa. RMP and the Regional PG Medical Faculty Project of Lee Hospital, Johnstown; 2 hrs. ea. day; 24 hrs. AAGP credit requested ea. year. Contact William W. Ayres, M.D., Pathologist, Somerset Community Hosp., 225 S. Center Ave., Somerset 15501.

Tunkhannock; March 17—May 19, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program) by Educational and Scientific Trust of PMS; at Tyler Memorial Hospital; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wellsboro; March 17—May 19, 1971

I—CURRENT MEDICAL AND SURGICAL CONCEPTS (An Edward Walter Clark Memorial Education Program); by Educational and Scientific Trust of PMS; at Soldiers & Sailors Hosp.; third Wed. ea. mo.; 9 hrs. AAGP credit applied for. Contact CES, Pennsylvania Medical Society, 20 Erford Road, Lemoyne 17043.

Wilkes-Barre; March 31—May 26, 1971

I/AMA—CONTINUING EDUCATION COURSE; by Hahnemann; at Wyoming Valley Hosp.; Wednesday each week. Contact David W. Kistler, M.D., D.M.E., Wyoming Valley Hosp., 149 Dana St., Wilkes-Barre 18702.

HEMATOLOGY

Pittsburgh; May 23, 1971—June 6, 1971

I—SEMINARS IN HEMATOLOGY; by Pitt; at Presbyterian-University Hosp.; 3 hrs. ea. day; 2 Sundays; 6 hrs. AAGP credit requested; $25 fee. Contact William M. Cooper, M.D., Dir., Div. of Cont. Edu., Pitt, 1022-G Scaife Hall, Pittsburgh 15213.

INTERNAL MEDICINE

As Requested, 1971; Philadelphia

PG—ACUTE CARE MEDICINE FELLOWSHIP (retraining program for women physicians); by Woman's; 6 hrs. per day; 1 yr. duration. Contact Ethel Weinberg, M.D., Assoc. Dean, Woman's, 3300 Henry Ave., Philadelphia 19129.

Philadelphia, October 6, 1971—May 31, 1972

I/AMA—INTERNAL MEDICINE REVIEW; at Hahnemann; 3 hrs. ea. day; 1 day ea. week; 33 weeks; 99 hrs. AAGP credit requested; $150 fee for entire course ($50 ea. subspecialty). Contact Mrs. Sage Cordell, Asst. Dir. PG Educ., Hahnemann, 230 North Broad Street, Philadelphia 19102.

Pittsburgh; September 13—October 15, 1971

I/AMA — INTERNAL MEDICINE REVIEW COURSE; by Pitt and Amer. Coll. of Physicians; at Pitt; 3 hrs. a day; 2 days ea. week; 5 weeks; 33 hrs. AAGP credit requested; $50 fee. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

MALIGNANT DISEASE

Philadelphia; September 9, 1970—June 23, 1971

I—CANCER DETECTION IN OFFICE PRACTICE; at American Oncologic Hosp.; 4 hrs. a day; 1 day a wk.; 20 hrs. AAGP credit approved; course repeated every 5 weeks. Contact Joseph G. Strawitz, M.D., Assoc. Dir., American Orcologic Hosp., Central & Shelmire Aves., Philadelphia 19111.

Sharon General Hospital; February 19—June 18, 1971

I—CLINICAL PROBLEMS IN ONCOLOGY; by Western Pa. RMP; 2 hrs. ea. day; third Fri. ea. mo. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

Warren General Hospital; February 9—June 8, 1971

I — CONTINUING EDUCATION PROGRAM (Cancer Subjects); by Western Pa. RMP; second Tues. ea. mo.; 2 hrs. ea. day. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

Washington Hospital; February 17—May 19, 1971

I—CONTINUING EDUCATION PROGRAM; by Western Pa. RMP; third Wed. ea. mo., 2 hrs. ea. day. Contact John B. Dunne, Chief Area Liaison Rep., WP/RMP, 3530 Forbes Ave., Pittsburgh 15213.

MICROBIOLOGY & IMMUNOLOGY

Allentown Hosp.; September 10, 1970—June 10, 1971

I—IMMUNOLOGY: BASIC CONCEPTS-CLINICAL APPLICATIONS (A Program of Continuing Medical Education; by Jefferson and Penn State; second Thurs. ea. mo.; 10 mos., 30 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc., Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

Danville; September 16, 1970—May 19, 1971

I — PSYCHIATRY AND COMMUNITY MENTAL HEALTH; by The Institute of Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. ea. day; 1 day a wk.; 10 weeks; 20 hrs. AAGP credit applied for. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Danville; September 24, 1970—May 27, 1971

I—PSYCHIATRY AND MEDICAL PRACTICE; by The Institute of the Pennsylvania Hosp.; at Geisinger Medical Center; 2 hrs. per day; 1 day a week; 20 weeks; 40 hrs. AAGP credit applied for $25 fee. Contact J. Martin Myers, M.D., Psychiatrist-in-Chief, Pennsylvania Hosp., 111 N. 49th St., Philadelphia 19139.

Norristown State Hospital; March 5, 1971—May 21, 1971

I/S—FAMILY THERAPY; by Norristown State Hospital; 2 hrs. each day; one day each week; 10 weeks; $50 fee. Contact John D. Pruitt, M.D., Dir. Cont. Educ. for Psychiatrists, Norristown State Hospital, Stanbridge and Sterigere Sts., Norristown 19401.

Philadelphia; October 21, 1970—June 2, 1971

I/AMA — SEMINARS IN PSYCHOTHERAPY; SHORT-TERM, CRISIS AND SUPPORTIVE THERAPIES; at Hahnemann; three 10-week seminars; every Wed.; 20 hrs. ea. seminar; AAGP credit requested; $75 fee for 10-week session, $150 for 30 sessions. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; April 7—May 12, 1971

I/AMA — DRUGS: PSYCHOTROPIC, PSYCHEDELIC AND ADDICTING; at Hahnemann; every Wed.; 6 weeks; 12 hrs. AAGP credit requested; $50 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; March 24—May 26, 1971

I/AMA — ADOLESCENCE AND THE YOUTH CULTURE; by Hahnemann; at Dept. of Psychiatry; every Wed.; 10 weeks; 10 hrs. AAGP credit requested; $75 fee. Contact Paul J. Fink, M.D., Dir. Psych. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CONTINUOUS COURSES

Sessions of the following courses will convene continuously until completed.

ANESTHESIOLOGY

May 27-29, 1971; Pittsburgh

C/LIFE SUPPORT-MAJOR ORGAN SYSTEM FAILURES (Fifth Annual Symposium on Acute Medicine) by Amer. Soc. of Anesthesiologists; at Pittsburgh Hilton; $100 fee. Contact Bulent Kirimli, M.D., c/o Dept. of Anesthes., V.A. Hosp., Pittsburgh 15240.

CARDIOVASCULAR DISEASE

Continuous; Philadelphia

PG/AMA (required credit)—Cardiology Tutorial Programs; by Hahnemann; 8 hrs. per day; 3 week minimum; 120 hrs. total; AAGP credit requested; $200 fee. Contact Mrs. Sage Cordell, Asst. Dir. Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

July 19—21, 1971; Philadelphia

C/AMA — BEDSIDE DIAGNOSIS OF HEART DISEASE; by Hahnemann; at Marriott Motor Hotel; 7 hrs. ea. day; 21 hrs. AAGP credit requested; $125 fee. Contact Bernard L. Segal, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

September 21—25, 1971; Philadelphia

C/AMA — CARDIAC ARRHYTHMIAS (Pathophysiology, Pharmacology and Treatment); by Hahnemann; at Marriott Motor Hotel; 7 hrs. ea. day; 4½ days; 31 hours. AAGP credit requested; $125 fee. Contact Mrs. Sage Cordell, Asst. Dir., PG Educ., Hahnemann; 230 N. Broad St., Philadelphia 19102.

September 27-28, 1971; Philadelphia

C/AMA—CURRENT TOPICS IN CARDIOPULMONARY DISEASE-1971: Evolving Concepts in Coronary Artery Disease; by American College of Cardiology; at Temple. Contact Miss Mary Anne McInerny, Dir., Dept. of Cont. Educ., American College of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014.

CHEST DISEASES

July 12-23, 1971; Philadelphia (Hahnemann)
October 4-15, 1971; Wilkes-Barre General Hospital
December 6-17, 1971; Philadelphia (Hahnemann)
March 14-25, 1972; Allentown Hospital

O/AMA—A Workshop in Respiratory Intensive Care; by Greater Delaware Valley RMP; 2 weeks; 5 days ea. week; 70 hrs. AAGP credit approved. Contact R. F. Johnston, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

November 1—12, 1971 (February 28—March 10, 1971); Philadelphia

C/PG — TEMPLE UNIVERSITY POSTGRADUATE COURSES IN BRONCHO-ESOPHAGOLOGY; by Drs. Charles M. Norris and Gabriel F. Tucker, Jr. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

ENDOCRINOLOGY

September 1—October 1, 1971; Philadelphia

PG/AMA—ENDOCRINOLOGY (DIABETIC) TUTORIAL COURSE; at Hahnemann; 7 hrs. per day; 20 days; 140 hrs. AAGP credit requested; $100 per week. $350 entire course. Contact Mrs. Sage Cordell, Asst. Dir. Postgraduate Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

GENERAL MEDICINE

June 14 - August 6, 1971; Philadelphia (repeat starting, October 11 and December 13, 1971)

PG/AMA (required credit)—Critical Care Medicine Tutorial Course, by Hahnemann; 8 hrs. per day (4 on Sat.); 47 days; 344 hrs.; AAGP credit requested, $300 fee. Contact Mrs. Sage Cordell, Asst. Dir. Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

September 13 - December 10, 1971; Philadelphia (repeat starting January 10, 1972)

PG/AMA (required credit)—Basic General Medicine Tutorial Course, by Hahnemann; 8 hrs. per day; 75 days; 528 hrs.; AAGP credit requested; $200 fee per mo. $500 entire course. Contact Mrs. Sage Cordell, Asst. Dir. Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

I/AMA—A PROGRAM OF CONTINUING MEDICAL EDUCATION; by Jefferson and Penn State; every Thurs.; 30 weeks; 3 hrs. AAGP credit approved ea. day; $40 fee ($8.00 single session). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Philadelphia; October 14, 1970—May 12, 1971

I/AMA—INTERNAL MEDICINE REVIEWS; by Hahnemann; at Alumni Hall; 3 hrs. a day; 1 day a week; 27 weeks; $150 fee ($70 per subspecialty); 81 hrs. AAGP credit approved. Contact Wilbur A. Oaks, M.D., Prog. Dir., Hahnemann, 230 N. Broad St., Philadelphia 19102.

HEMATOLOGY

June 7 - July 2, 1971; Philadelphia (repeat beginning October 4, 1971)

C/PG/AMA — HEMATOLOGY & MEDICAL ONCOLOGY TUTORIAL COURSE; by Hahnemann; 7 hrs. ea. day; 5 days ea. week; 4 weeks; $350 fee ($100 per week). Contact Mrs. Sage Cordell, Asst. Dir., PG Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

INTERNAL MEDICINE

Continuous; Philadelphia

PG/AMA (required credit)—Clinical Rheumatology Tutorial Course; by Hahnemann; 8 hrs. per day; 2 days per week; 4 weeks; 64 hrs. total; AAGP credit requested; $100 fee. Contact Mrs. Sage Cordell, Asst. Dir. Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Continuous (2-4 weeks in any subsection); Philadelphia

PG/AMA (required credit)—Hypertension, Dialysis and Clinical Nephrology Tutorial Course; by Hahnemann; 8 hrs. per day. AAGP credit requested; Fee: $75 per week. Contact Mrs. Sage Cordell, Asst. Dir. Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Continuous (3 weeks in any subsection); Philadelphia

PG/AMA (required credit)—Multiple Clinical and Laboratory Pulmonary Tutorial Courses; by Hahnemann; 8 hrs. per day; 120 total hours; $250 fee. Contact Mrs. Sage Cordell, Asst. Dir. Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

May 19—21, 1971; Philadelphia

C/AMA—PATHOPHYSIOLOGY OF PULMONARY DISEASE; by U. of Pa.; at Annenberg Center of Communications; 7 hrs. ea. day; 21 hrs. AAGP credit requested; $125 fee. Contact Office of Grad. Med. Educ., U. of Pa., 283 Med. Labs. Bldg., Philadelphia 19104.

May 17 - July 9, 1971; Philadelphia (repeat starting September 20, 1971 & February 21, 1972)

PG/AMA (required credit)—Immunology (allergy) Tutorial Course; by Hahnemann; 8 hrs. per day; 40 days; 320 hrs.; AAGP credit requested; $200 fee. Contact Mrs. Sage Cordell, Asst. Dir. Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 4—15, 1971; Philadelphia

C/PG/AMA—EMERGENCY ROOM TUTORIAL COURSE; by Hahnemann; 7 hrs. ea. day; 10½ days; 70 hrs. AAGP credit requested; $400 fee includes daily lunches. Contact Mrs. Sage Cordell, Asst. Dir. PG Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

January 3-7, 1971; Philadelphia

AMA—Workshops in the Physiology, Pathophysiology and Diagnosis of Disorders of Electrolyte and Acid-Base Metabolism; by Amer. Coll. of Physicians; at Hospital of the Univ. of Pa.; Fee: Members and F.A.C.P. $80, non-members $125, candidate members and ACP Latin American Fellows $40. Contact Registrar, Postgraduate Courses, Amer. Coll. of Physicians, 4200 Pine St., Philadelphia 19104.

March 20-24, 1972; Philadelphia

AMA—Specifically Treatable Diseases (Emphasizing Pathophysiology and Early Clinical Findings); by Amer. Coll. of Physicians; at Pennsylvania Hosp. and U. of Pa.; Fee: Members and F.A.C.P. $80, non-members $125, candidate members and ACP Latin American Fellows $40. Contact Registrar, Postgraduate Courses, Amer. Coll. of Physicians, 4200 Pine St., Philadelphia 19104.

NEPHROLOGY

June 7—9, 1971; Philadelphia (to be repeated June, 1972)

C/AMA—NEPHROLOGY FOR THE PRACTICING PHYSICIAN; by Hahnemann; at Holiday Inn; 7 hrs. ea. day; 3 days; 21 hrs. AAGP credit requested; $125 fee. Contact Mrs. Sage Cordell, Asst. Dir. PG Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

NEUROLOGY

May 10 - July 30, 1971; Philadelphia (repeat starting September 13, 1971)

PG/AMA (required credit)—Neuropathology, Adult & Pediatric Neurology Tutorial Course; by Hahnemann; 8 hrs. per day; 58 days; 464 hrs. total; AAGP credit requested. Contact Mrs. Sage Cordell; Asst. Dir. Cont. Educ., Hahnemann; 230 N. Broad St., Philadelphia 19102.

May 26—28, 1971; Philadelphia

C/AMA—NEWER ASPECTS OF NEUROLOGY AND NEUROSURGERY; by U. of Pa.; at Hospital of U. of Pa., 7 hrs. ea. day; 21 hrs. AAGP credit requested; $100 fee. Contact Office of Grad. Med. Educ., 288 Med. Labs. Bldg., Philadelphia 19104.

OPHTHALMOLOGY & OTOLARYNGOLOGY

May 19—22, 1971; Bedford

C—1971 SCIENTIFIC MEETING OF PA. ACAD. OF OPHTHALMOLOGY AND OTOLARYNGOLOGY; at Bedford Springs Hotel; $35 fee for non-members; all physicians welcome. Contact Joseph A. Cipcic, M.D., (Secy. Pa. Acad. of O & O), 1501 Locust St., Pittsburgh 15219.

August 2—6, 1971; Pittsburgh

C/S—THE MANAGEMENT OF RETINAL DETACHMENT; by Pitt.; at Eye & Ear Hosp.; 8 hrs. ea. day; 5 days; $300 fee. Contact William G. Everett, M.D., Dir., Eye & Ear Hosp., 230 Lothrop St., Pittsburgh 15213.

PEDIATRICS

May 11—14, 1971; Philadelphia

C—TWENTIETH ANNUAL SEMINAR IN PEDIATRICS; by Temple; at St. Christopher's Hosp., for Children; 28 hrs. AAGP credit requested; $100 fee. Contact John B. Bartram, M.D., St. Christopher's Hosp. for Children, 2600 N. Lawrence St., Philadelphia 19133.

PSYCHIATRY

May 19, 1971; Philadelphia

C—CONTINUING EDUCATION IN PSYCHIATRY (1971 Teachers Conference); by Pa. Steering Com. for Cont. Educ. in Psychiatry. Contact William H. Lentz, Jr., Exec. Dir., Steering Com., 5600 Derry St., Harrisburg 17111.

June 16, 1971; Philadelphia

AMA—The Encounter Movement in Psychiatry; by Hahnemann; at Marriott Motor Hotel; 8 hrs.; $35 fee. Contact Paul J. Fink, M.D., Dir. Education and Training, Hahnemann; 249 N. Broad St., Philadelphia 19107.

1971 Scientific Assembly Clinical Therapeutics—1971: Emergency Medicine Monday, November 8 — Thursday, November 11, 1971

Seminars:

Pennsylvania Medical Society
Pennsylvania Nurses Association
Pennsylvania State University College of Medicine (Hershey)
Medical College of Pennsylvania
Temple University School of Medicine
University of Pennsylvania School of Medicine
Pennsylvania Allergy Association
Society of Colon and Rectal Surgery
Pennsylvania Academy of Ophthalmology and Otolaryngology
Pennsylvania Orthopaedic Society
Pennsylvania Academy of Physical Medicine and Rehabilitation
Pennsylvania Psychiatric Society
International College of Surgeons, Pennsylvania Division
Urological Association of Pennsylvania
Pennsylvania Academy of General Practice
Pennsylvania Division, American Cancer Society
Pennsylvania Society of Internal Medicine
PMS Commission on Geriatrics

new members

These physicians have joined the State Society recently:

ALLEGHENY COUNTY:
Siegfried P. Junghans, M.D., Sewickley Valley Hospital, Sewickley 15143.
Lawrence N. Adler, M.D., Forest Hills Plaza, Pittsburgh 15221.

BEAVER COUNTY:
Jose F. Garcia, M.D., 1909 College Ave., Beaver Falls 15010.

BERKS COUNTY:
Thomas B. Souders, M.D., 424 Walnut St., Reading 19601.
James M. Fenstermacher, M.D., Anes. Dept., Reading Hospital, Reading 19602.

BUCKS COUNTY:
Jung-Soo Jung, M.D., 523 W. Broad St., Quakertown 18951.

BUTLER COUNTY:
Laura May Cameron, M.D., V.A. Hospital, Butler 16001.
John A. Knapp, M.D., BAH #529, Butler 16001.

CAMBRIA COUNTY:
Camille J. Maravalli, M.D., 406 Main St., Johnstown 15901.
Rodolfo L. Furigay, M.D., Windber Hosp., Windber 15963.
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obituaries

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Joseph J. Austra,** Shenandoah; Jefferson Medical College, 1916; age 77; died January 17, 1971. He is survived by a daughter, a son, and a brother.

○ **William B. Barr Jr.,** Allentown; Jefferson Medical College, 1956; age 41; died February 14, 1971. Associated with his father, Dr. William B. Barr, Sr. in private practice, he was a fellow of the American Abdominal Assn. and had won a fellowship in surgery at Duke University. Besides his wife and two sons, he is survived by his parents, two sisters, and a brother, Dr. Gavin C. Barr of Bethlehem.

○ **Charles C. Grouse,** Greensburg; University of Pennsylvania Medical School, 1915; age 82; died January 19, 1971. He was a fellow in the Medical College of Surgeons. One daughter survives him.

○ **Abram A. Dattner,** Wilkes-Barre; Jefferson Medical College, 1915; age 79; died January 29, 1971. A pediatrician, in later years he was assistant regional director of Pennsylvania State Department of Health. He is survived by his wife, a daughter, a son, and three brothers, one of whom is Herman B. Dattner M.D., of Wilkes-Barre and six sisters.

○ **Jacob Gershon-Cohen,** Philadelphia; University of Pennsylvania School of Medicine, 1924; age 72; died February 6, 1971. Dr. Gershon-Cohen was director emeritus of radiology at the Albert Einstein Medical Center. Besides holding several professorships at Temple University School of Medicine and at the University of Pennsylvania Hospital, he was the first president of the American Thermographic Society and president of the Philadelphia Roentgen Ray Society. He is survived by two sisters and and a brother.

○ **Frederick Nelson Groves,** Pittsburgh; University of Pittsburgh School of Medicine, 1930; age 65; died January 31, 1971. He is survived by a brother and a sister.

○ **Louis Robert Guerrieri,** Scranton; Georgetown University Medical College, 1956; age 40; died January 25, 1971. He was chief of neurosurgery at Scranton State General Hospital. He is survived by his wife and one child.

○ **Robert W. Henry,** Philadelphia; Leonard Medical School, 1907; age 87; died October 10, 1970. He was president of Philadelphia Academy of Medicine and Allied Sciences and president of The Medical Society of Eastern Pennsylvania. His wife survives him.

○ **G. Norris Ketcham,** Philadelphia; Temple University School of Medicine, 1941; ae 55; died January 25, 1971. He was a fellow of the American College of Obstetrics and Gynecology. Survivors include his wife, a son, a daughter, and a sister.

○ **S. Meyer Klein,** Lewistown; Medical College of Virginia, 1931; age 64; died February 11, 1971. A physician in Lewistown for the past twenty-five years, he is survived by his wife, a daughter, and a step-daughter.

○ **Clarence L. Lehman,** Springfield; Temple University School of Medicine, 1943; age 52; died January 5, 1971. Dr. Lehman had been a teaching associate at Temple Medical School and was chief of pathology at Crozer-Chester Medical Center. He was a fellow of the College of American Pathologists, the American Society of Clinical Pathologists, and the Pennsylvania Society of Clinical Pathologists. He is survived by his wife, two daughters, and a son.

○ **Lewis R. McCauley,** Punxsutawney; Hahnemann Medical College, 1933; age 67; died January 28, 1971. He was a fellow in the American College of Physicians and the American College of Cardiology. Survivors are his wife and a daughter.

○ **Joseph E. Novotny,** Donora; University of Pittsburgh School of Medicine, 1927; age 70; died December 15, 1971. He is survived by a brother.

○ **Walter A. Shuman,** Lititz; Temple University School of Medicine, 1946; age 57, died February 6, 1971. He was a diplomate on the American Board of Anesthesiology. His wife survives him.

○ **Aida Sloan,** Pacific Palisades, Cal.; University of Pittsburgh School of Medicine, 1909; age 82; exact date of death unknown. A specialist in ophthalmology, her son, Dr. Howard Sloan, predeceased her.

Guy B. Anderson, Mohnton; Jefferson Medical College, 1920; age 80; died January 28, 1971. He practiced in Baltimore until his retirement in 1963. He is survived by his wife, a daughter, two sisters, and a brother.

Maryesther Burns, Selinsgrove; Woman's Medical College, 1918; age 84; died October 2, 1970. There are no known survivors.

Thaddeus Leslie Deren, Moorestown, N.J.; Hahnemann Medical College; 1954; age 44; died February 4, 1971. Dr. Deren was chief of urology at Rancocas Valley Hospital in Willingboro, N.J. and was on the staff at Hahnemann and St. Luke's Hospitals in Philadelphia. Survivors include his wife, one daughter, two sons, his mother, and a sister.

Josephine Fundenburgh, Neffsville; University of Michigan, 1913; age 89; died February 18, 1971. A psychiatrist, she practiced at state hospitals in Mercer, Norristown, and Torrance. She is survived only by nieces and nephews.

Domenic A. Rovito, Middletown; University of Rome, Italy, 1934; age 61; died February 3, 1971. He was chief of psychiatric services at Veterans Administration Office at Wilmington, Del. at the time of his death. His wife, a daughter, two sons, three sisters, and three brothers (among them Joseph Rovito M.D., of Morton and S. Samuel Rovito M.D., of Merion) survive him.

Kurt J. Wolff, Coatesville; Frederick Williams University, Berlin, Germany; age 63; died February 10, 1971. Specializing in geriatrics and psychiatry, he was chief of staff for research and education at the Veterans Administration Hospital in Coatesville at the time of his death. He is survived by his wife and a brother.

meetings

MAY

Nineteenth Annual Clinical Meeting of the American College of Obstetricians and Gynecologists, **May 3-6, 1971,** San Francisco, Cal. Non-Fellows may register to attend the meeting and the postgraduate courses preceding the meeting (May 1 and 2). For further information contact: Donald F. Richardson, 79 West Monroe St., Chicago, Ill. 60603.

National Symposium on Emergency Medical Care, **May 6-7, 1971,** Bellevue Stratford Hotel, Philadelphia. Sponsored by The Delaware Valley Council and cooperating organizations. Chairman: John M. Howard, M.D., Professor Surgery, Hahnemann Medical College & Hospital, Philadelphia 19102.

1971 Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, **May 12-14, 1971,** Baltimore Civic Center. No registration fee. Credit given by the Academy of General Practice. For complete program write: Arlie R. Mansberger, Jr., M.D., Chairman, Committee on Program and Arrangements, Medical and Chirurgical Faculty, 1211 Cathedral St., Baltimore, Md., 21201.

Fourteenth Annual Convention of the Pennsylvania chapter of the American Association of Medical Assistants, **May 13-16, 1971,** Chatham Center, Pittsburgh.

Annual Meeting of the National Tuberculosis and Respiratory Disease Association and the American Thoracic Society, **May 16-19, 1971,** Los Angeles Hilton Hotel, Los Angeles, Cal. For further information contact: Miss Helen Jones, National TB & RD Association, 1740 Broadway, New York, N.Y. (212) 245-8000.

Annual Meeting of the Pennsylvania Academy of Ophthalmology and Otolaryngology, **May 19-22, 1971,** Bedford Springs Hotel, Bedford. For further information contact: Joseph A. Cipic, M.D., 1501 Locust St., Pittsburgh 15219.

JUNE

AMA Annual Convention, **June 20-24, 1971,** Atlantic City, N.J.

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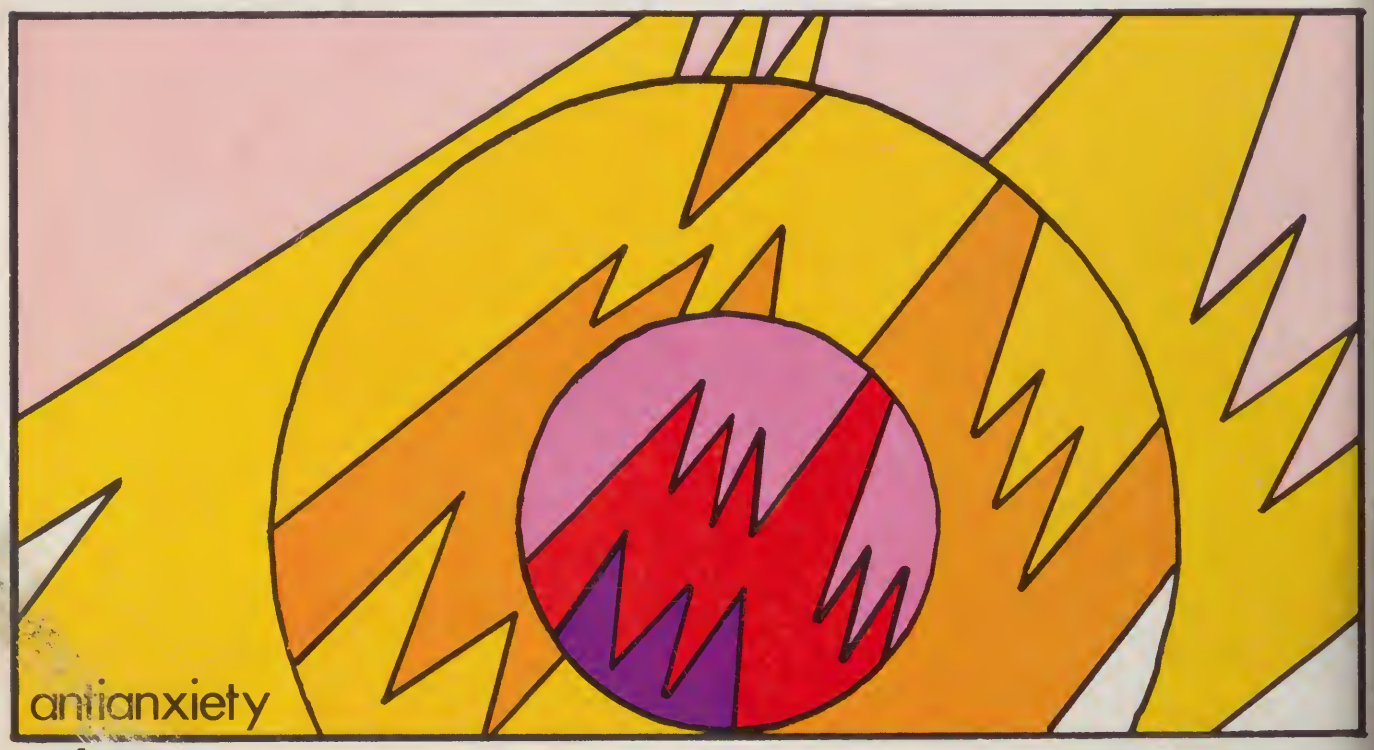

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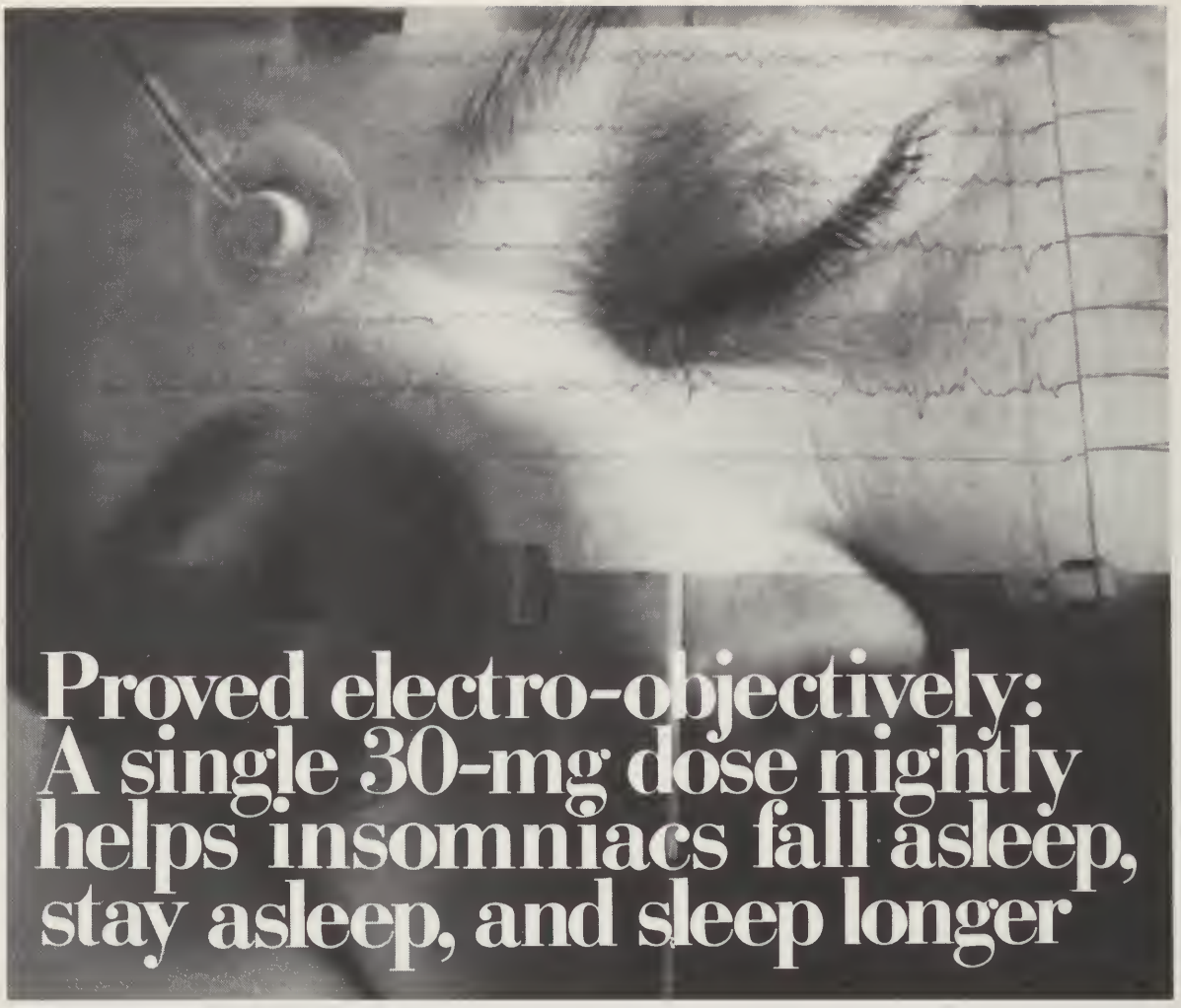

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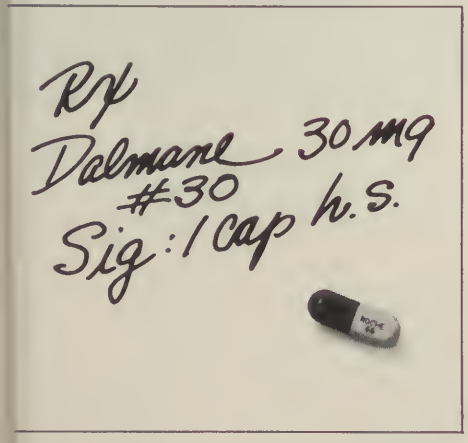
References: 1. Kales, A., *et al.*: "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. **2.** Kales, A., *et al.*: "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology,* Phila., Lippincott, 1969, p. 331. **3.** Data on file, Medical Department, Hoffmann-La Roche Inc.



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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.,* excitement, stimulation and hyperactivity, have also been reported in rare instances.

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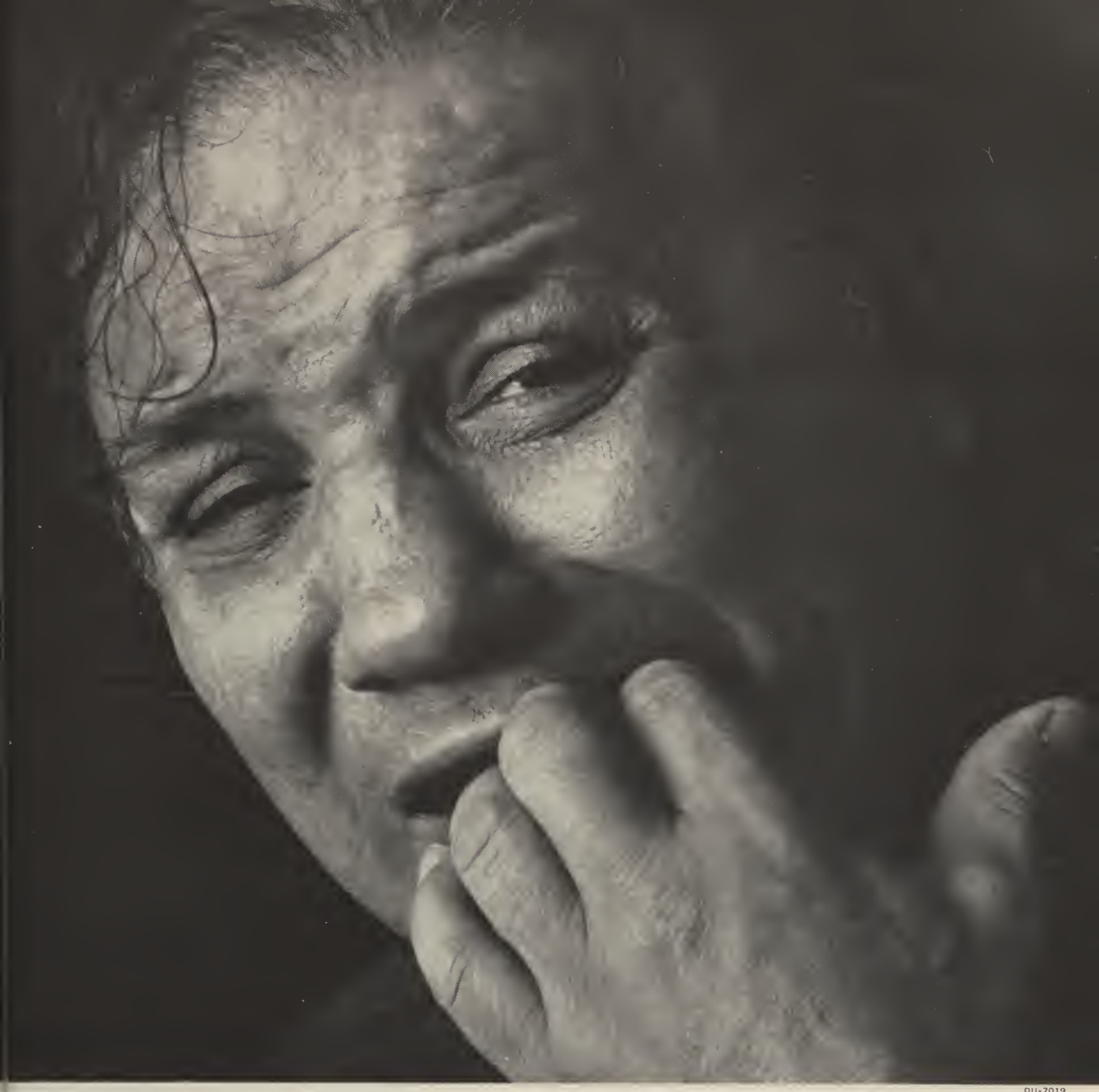

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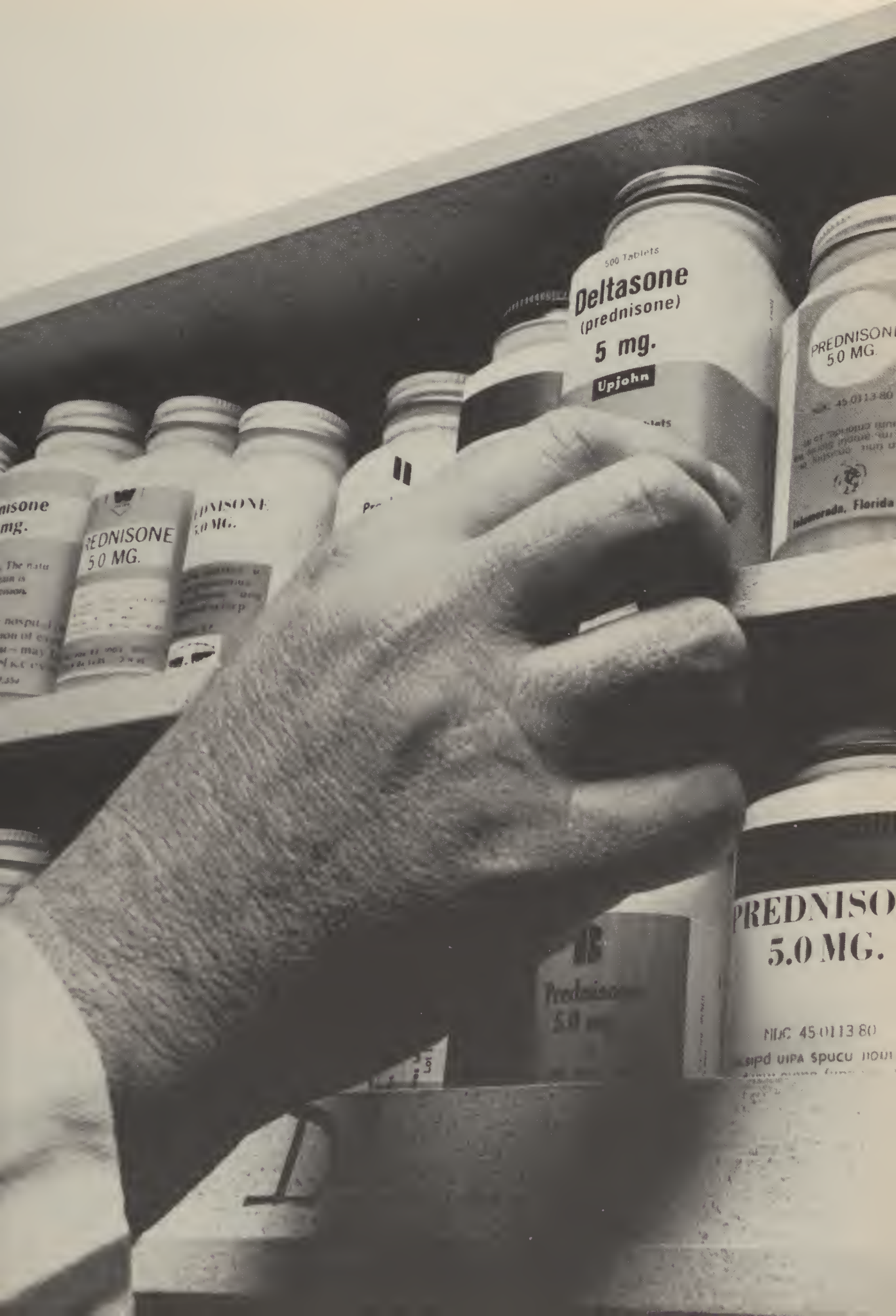
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The potency of prednisone exceeds cortisone in glucocorticoid and anti-inflammatory activity by about five times on a weight basis, but is considerably less active than cortisone in mineralocorticoid activity.

Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. *Important:* Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptomatically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9-alpha-fluro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoids during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis, an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and, whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angiitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

Supplied: 2.5 mg., scored—bottles of 100 tablets. 5 mg., scored—bottles of 100 and 500 tablets and cartons of 100 tablets in foil strips.

For additional product information, consult the package insert or see your Upjohn representative.

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Before prescribing, please consult complete product information, a summary of which follows:

INDICATION: Relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

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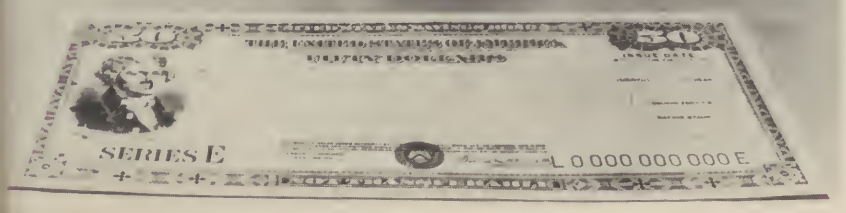

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At last-an answer to your malpractice protection anxiety.

An insurance program sponsored and supported by the PMS.

The Pennsylvania Medical Society has been increasingly concerned about the problems faced by its members in securing and retaining professional liability insurance. There has been a growing tendency for insurance carriers to arbitrarily cancel, or not renew, professional liability insurance contracts for reasons entirely beyond the physician's control.

The obvious answer had to be a program, sponsored by the Pennsylvania Medical Society, designed to provide its members with *long term* coverage, adequate limits, at the best possible cost, in addition to giving the Society an opportunity to participate in the policy-making and administration of the program.

Such a program, more progressive and comprehensive than any that has been made available to any medical group, now exists. It is being underwritten by the Argonaut Insurance Company, a well established, "A+AAAA" rated casualty insurance carrier with assets in excess of $180,000,000 and considerable experience in the medical liability field. The exclusive, full-time administrator of the program is Parker & Co. Inc. of Pennsylvania, one of the country's leading insurance brokerage firms.

In review, the major points of the program are:

1. The Pennsylvania Medical Society has entered into an agreement with the Argonaut Insurance Company to administer the program through Parker & Co., Inc. of Pennsylvania.
2. The Argonaut Insurance Company will be bound to make this program available for a *minimum of five years. No* other carrier has offered such an agreement.
3. The Society participates through a Professional Liability Insurance Commission consisting of twelve members. The Commission will be the ultimate authority in appeals stemming from disputes between member insureds and will work in close conjunction with the local district committees.
4. No member's application will be declined except by the *joint decision* of the PMS Commission and the Argonaut Insurance Company.
5. Full liability coverage of $100,000 for each claim with an annual aggregate limit of $300,000 with excess limits up to $1,000,000 available. Coverage *is* available for interns, residents and physicians' and surgeons' assistants.
6. Rates are competitive with other major writers of professional liability insurance in Pennsylvania.
7. There is no requirement that a member purchase ancillary insurance coverages (homeowners, auto, etc.) in order to participate.

This program offers PMS members a unique opportunity to stabilize their professional liability insurance coverage on a long term basis. However, a broad based, high degree of membership involvement is essential to make this program a success. Please fill out the coupon indicating your interest in participating in the PMS endorsed program when your present coverage expires.

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Telephone No. _____

Medical Specialty_____

Date your professional liability insurance expires _____

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I am interested in participating in the PMS Professional Liability Insurance Program. Please send me an application. ☐

EXPERIMENTAL HMO ANNOUNCED BY GOVERNOR Governor Shapp has announced that the state is setting up an experimental program to provide nearly unlimited medical care for the poor. The $2.8 million venture is to be carried out by Temple University in a section of Philadelphia where a large number of welfare recipients live. In essence the plan would establish a Health Maintenance Organization (HMO), a pre-payment plan which would provide comprehensive health care and would have as members both those who could pay premiums and those on welfare, whose premiums would be paid to the HMO by the state. The facilities now operated by Temple in the Hartranft and West Nicetown-Tioga comprehensive health group service centers (described in the April issue of PENNSYLVANIA MEDICINE, page 31) apparently will be used. Details will appear in future issues.

PMS TO SERVE AS ANATOMICAL GIFTS FACTS AGENCY The PMS Board of Trustees at its May 12 meeting voted to approve a proposal of the Council on Public Service that the State Society act as an interim anatomical gift information agency and conduct a public education campaign if funds are available from outside sources to meet part of the cost. Additionally the Board voted to support legislative efforts to restructure the Anatomical Gift Board and to fund it as an agency under the Department of Health. That board then would perform the work the State Society will do on an interim basis. Since the Anatomical Gift Act was signed in January of 1970, it has had no impact on the scarcity of bodies for teaching purposes, or the shortage of body parts because no effort has been made to inform the public of the steps to be taken to make a gift.

FYI (FOR YOUR INFORMATION) The May 1 deadline for using physician Bureau of Narcotics and Dangerous Drugs (BNDD) registration numbers under the Controlled Substances Act has been extended to July 29. Many physicians who have applied have not yet received their BNDD numbers. They may continue to practice as before, indicating "Federal registration applied for on (date)" instead of the BNDD registration number. The May issue of PENNSYLVANIA MEDICINE has a rundown of the new rules on page 45 ...Response to the State Society's group malpractice program has been called "heartening" following the initial announcement in a letter to members from PMS President William A. Limberger, M.D., and the publication of a report by R. Robert Tyson, M.D., Philadelphia, chairman of the PMS Commission on Professional Liability Insurance in the May issue of PENNSYLVANIA MEDICINE. Details can be found in that issue on page 17...The American Academy of Pediatrics has sounded a warning to parents not to permit their children to use products for oral use, such as tooth paste or throat lozenges, which contain hexachlorophene, a chlorinated hydrocarbon, which caused the death of a toddler who ingested a few ounces of a 3 percent solution...

Pennsylvania M.D.'s present at the AMA Convention in Atlantic City, June 19, will witness an interesting presidential election, the candidates being Charles E. Hoffman, M.D., Huntingdon, W.Va., and Claude E. Welch, M.D., Boston, Mass...The AMA has issued a statement through its Council on Environmental Affairs urging individual physicians and state and county medical societies to give the fight against venereal disease top priority. Individual physicians are urged to cooperate with public health departments by reporting cases.

OTHER EVENTS AT THE BOARD MEETING The Board also: Determined to recommend to the 1971 House of Delegates that the Medical Defense Fund be restructured to provide defense only to component societies or to special precedent-setting cases as the Board decides...Referred to the Council on Education an Science an Interspecialty Committee recommendation to form a task force on Physician Assistants...Approved the recommendation of PMS President William A. Limberger, M.D., that David M. Besselman, M.D., Harrisburg, be appointed as delegate to the Interspecialty Committee from the Pennsylvania Chapter of the American Academy of Pediatrics ...Confirmed the appointments of President-Elect George P. Rosemond, M.D., to the four councils of the State Society. The appointments wil appear in the next issue of PENNSYLVANIA MEDICINE...Enlarged the Lay Advisory Committee by adding four persons...Reappointed William J. Kelly, M.D., Pittsburgh, trustee from the Tenth Councilor District, as PMS representative to the State Board of Medical Education and Licensure...Voted to support the deans of Pennsylvania's medical schools in the request to the Legislature for financial aid in the 1971-72 school year...Heard verbal reports from Secretary of Health J. Finton Speller, M.D., M. Lorenzo Walker, M.D., president of the Keystone Medical Society, and William B. West, M.D., chairman of PaMPAC. Dr. Speller said he is proceeding to establish a permanent liaison committee of the Department of Health and the State Society. Dr. Walker invited board members to attend the convention of the National Medical Association in Philadelphia in August. The 300-member Keystone Medical Society is the Pennsylvania component of the National Medical Society.

CHIROPRACTIC MEASURES HIT LAWMAKERS Three bills, House Bills 816, 817 and 818, have been introduced all at the same time, all referred to the same committee--the Committee on Professional Licensure, and all with the same chief sponsor, Ulysses Shelton of Philadelphia, who also is chairman of the Committee on Professional Licensure. H.B. 816 would require insurance companies to pay for chiropractic services when the company pays other practitioners for similar services. H.B. 817 is an amendment to the Chiropractic Practice Act which would permit the Board of Chiropractic Licensure to promulgate and enforce rules of "professional conduct appropriate to establish and maintain a high standard of integrity and dignity in the profession of chiropractic. H.B. 818 would amend the so-called "Statutory Construction Act," which defines many of the terms used throughout the state's legal code, to include chiropractors under the term "physician" as well as doctors of medicine and osteopathy. The Society has voiced its vigorous opposition to the last bill in a letter from President Limberger to all members of the committee.

Deans accept checks for medical schools

Pennsylvania's seven medical schools received $57,600 in grants from the AMA Education and Research Foundation on May 12.

At the same time, the Educational and Scientific Trust of the Pennsylvania Medical Society announced that direct aid of more than $158,000 has been provided to state students during the current school year.

In the medical school grants, Philadelphia area institutions and amounts were: University of Pennsylvania School of Medicine, $13,714; Jefferson Medical College, $8,204; Medical College of Pennsylvania, $5,178; Hahnemann Medical College, $8,339; and Temple University School of Medicine, $11,263. The University of Pittsburgh School of Medicine received $7,914 and the new Hershey Medical Center of Pennsylvania State University College of Medicine, $2,983.

In presenting the checks at a meeting of the Pennsylvania Medical Society Board of Trustees, the board chairman, Dr. Park M. Horton, M.D., of New Milford, told the medical school representatives that "the funds may be used at your discretion for whatever projects you determine to be in the best interest of your school and the public."

The grants are part of nearly $1 million contributed in 1970 by physicians, their wives, medical societies and other sources through the AMA foundation to medical schools in the U.S. and Canada. Since 1960, the total exceeds $12 million.

Dr. Horton said the $158,000 in aid provided by the Trust of the state society benefited 170 Pennsylvania students with scholarship and loans during the 1970-71 school year, a slight increase over previous years. Since 1951, the total is about $1.4 million.

In addition, a student loan guarantee fund established to alleviate financial difficulties of medical students, interns and residents and to encourage medical career decisions, also is financed by contributions received by the AMA foundation.

RECEIVING checks at a joint meeting of the medical school deans and the PMS Board of Trustees from Park M. Horton, M.D., right, chairman of the board, are, left to right: Joseph R. DiPalma, M.D., dean of Hahnemann Medical School; Hartwell G. Thompson, M.D., associate dean, University of Pennsylvania Medical School; William F. Kellow, M.D., dean, Jefferson Medical College; Bernard Sigel, M.D., dean, Medical College of Pennsylvania; and William P. Barba II, M.D., acting dean, Temple University School of Medicine. Also at the meeting but missing from the picture are George T. Harrell, M.D., dean of Pennsylvania State College of Medicine, Hershey, and Donald N. Medearis, M.D., dean of the University of Pittsburgh School of Medicine.

The AMA fund has guaranteed loans totaling about $48.6 million to 43,631 students, interns and residents since the program's inception in 1962.

Of this amount, 1,778 loans totaling more than $2 million were made to students attending Pennsylvania medical schools and to interns and residents in the state.

Allegheny County doctors discuss pollution problems

A symposium on "The Physician and His Environment" was held recently by the Allegheny County Medical Society for physicians and their wives. Peter Safar, M.D., of the University of Pittsburgh School of Medicine, was chairman of the committee on environmental problems which planned the program devoted mainly to discussions on air pollution. The meeting concluded with Dr. Safar's evaluation of the relationship of the physician to this problem.

Blue Shield committee meets

The Pennsylvania Blue Shield Planning and Study Committee, organized last year, has held the first of several meetings scheduled for 1971, Allen W. Cowley, M.D., Harrisburg, chairman of the Blue Shield Board of Directors, has announced.

The fifteen-member group includes representatives of the medical profession, business, and consumers who are also members of the Blue Shield Board of Directors or Subscriber Advisory Council.

The new committee is charged with studying and developing ways to provide more health care benefits to Blue Shield subscribers at reasonable cost.

Seven of the fifteen members are physicians. Eight represent business and consumer groups. The physicians are Drs. R. Robert Tyson, Philadelphia; Lewis T. Buckman, Wilkes-Barre; A. Reynolds Crane, Philadelphia; John F. Drumheller, Erie; Wilbur E. Flannery, New Castle; Victor J. Margotta, Scranton and Dr. Cowley.

Health careers sought by qualified veterans

A program to utilize the health skills of veterans of the armed services is being sponsored by the Hospital Education and Research Foundation (HERF), an agency of the Hospital Association of Pennsylvania.

HERF was selected to operate the program in Pennsylvania by the Departments of Defense and Health, Education and Welfare. Called Operation MEDIHC (Military Experience Directed into Health Careers), the aim of the nationwide program is to cooperate with public and private agencies and professional organizations to make use of the medical skills acquired by veterans during their years of service. In Pennsylvania the program is already in operation.

More than 450 servicemen, most of whom have been discharged from military service, are already listed with MEDIHC. They range in age between twenty and fifty years and come from all three major branches of the service. Their service training runs the gamut from medical corps work, acromedical evacuation, dispensary duty, technician and x-ray training, medical and surgical ward experience, amputee care, physical therapy, through dentistry and psychiatry.

Their areas of interest include all phases of hospital work, nursing, physical therapy, technology and radiology, as well as social work. Specific positions sought are for physicians' assistants, general medical assistants, anesthesiologists, pharmacists, nurses, and all branches of hospital work.

Some have business management and science backgrounds in addition to their service experience. Geographical preferences show requests for all parts of the state. For further information and for specific names and addresses, contact the MEDIHC Program, P.O. Box 608, Camp Hill 17011 or telephone: (717) 233-7621, ext. 42.

Patient service departments discussed at Jefferson

"Looking at the hospital from the patient's point of view" was the theme of the meeting of 150 patient service representatives of seventy-eight hospitals sponsored by Thomas Jefferson University Hospital recently.

Floyd Cornelison, M.D., chief of the psychiatry department at Jefferson Medical College and Thomas Jefferson University Hospital, who spoke at the meeting, emphasized the need for listening to the patient. "Few other professionals in the hospital have the time to really listen to what patients want to say," Dr. Cornelison said. "It is a great boon to therapy if the patient feels he will be listened to without bias, and learning to listen to a patient is an art." Dr. Cornelison went on to discuss situations in which patients who are depressed, anxious, or angry are in reality expressing normal reactions to fear or loss. "The sensitive listener knows this," he said.

The group voted to form a national organization of hospital patient service departments.

State medical society planning drug abuse training institute

With the cooperation of Pfizer Laboratories, the Pennsylvania Medical Society is sponsoring a drug abuse training institute to be held June 12 and 13 at the Marriott Motor Inn in Philadelphia. Paul J. Poinsard, M.D., chairman of the PMS Commission on Mental Health and Mental Retardation, will preside over sessions on the pharmacology of drugs, the laws governing them, and the problems produced by them, Richard B. Magee, M.D., chairman of the Council on Education and Science, said.

The faculty will include Donald B. Louria, M.D., president of the New York State Council on Drug Addiction; Roger Smith, executive director of Marin Open House in San Rafael, California; Catherine B. Hess, M.D., narcotics advisor for the Pennsylvania Department of Health; David E. Smith, M.D., founder and director of the Haight-Ashbury Free Medical Clinic, San Francisco; Edward A. Wolfson, M.D., director of the division of drug abuse at the College of Medicine and Dentistry of New Jersey; John Ruocco, president and director of Gaudenzia House, Philadelphia; Sanford J. Feinglass, member of the California Interagency Council on Drug Abuse; and Stanley Einstein, editor and founder of the *International Journal of the Addictions*.

The registration fee (including two lunches) is $30, which is tax deductible for educational expenses. Credit for 14 hours has been applied for to AAGP and to ACGP. The AMA will grant 14 hours of credit toward the physician recognition award.

Dr. Magee announced that attendance will be restricted to 150.

'Search Committee' seeking new deputy

A special "Search Committee" headed by H. Keith Fischer, M.D., Philadelphia, has been established by the State Advisory Committee for Mental Health and Mental Retardation to interview applicants and make recommendations for the appointment of a deputy secretary of mental health and mental retardation to succeed Joseph Adlestein, M.D., whose resignation is effective July 1.

The special committee consists of the advisory committee members plus seven leaders in activities for the mentally disabled.

Members of the Advisory Committee for Mental Health and Mental Retardation, besides Dr. Fischer, are: Mrs. Eleanor J. Kephart, Meadville; Richard J. Tyner, Camp Hill; State Supreme Court Justice Samuel J. Roberts, Erie; and Drs. Elizabeth H. Boggs, Hampton, N.J.; Lauren H. Smith, Bryn Mawr; and Jack Wolford, Pittsburgh.

Those added to the group to form the "Search Committee" include Paul J. Poinsard, M.D., Philadelphia, chairman of the PMS Commission on Mental Health/Mental Retardation. Others are James R. Wilson, Jr., Philadelphia; Herbert G. Clark, Ambler; Mrs. Jack W. Robbins, Fort Washington; Carl L. Saylor, Lewistown; Victor Wilburn, Philadelphia, and Dr. Richard J. Hess, Millersville.

Health care quality, financing explored

Quality and financing of medical care in the coming decade was the theme of the 1971 PMS Officers' Conference attended by over 200 county society leaders from throughout the state.

U.S. Representative Daniel J. Flood, twenty-six-year veteran in the nation's legislative halls, representing Pennsylvania's Eleventh Congressional District, told his audience that the nation has experienced a dramatic and sudden demand for an increase in health services, and that this surge of interest has caused to be introduced into the Congress a large number of proposals for improvement of the delivery of health care, both from the financing aspect and from the point of view of quality and availability.

He said emphatically that "there is not enough manpower to go around," a position taken by the State Society as well, and pointed out that more people are in need of care because the population in ten years has increased 20 percent, and because there has been an even greater increase percentage-wise in those age groups needing more health services—the aged and the very young.

Financing Discussed

Second in seniority on the powerful House Appropriations Committee and chairman of its Subcommittee on Labor, Health, Education, and Welfare, Rep. Flood said, "When this can of worms in Vietnam washes out, we're going to cut $15 billion from the military budget. . .I want $5 billion for health, education, and welfare. And what Dan Flood wants, he usually gets." The last sentence was a phrase he repeated with flourish several times during his speech. He indicated the budget request for HEW this year would be $20 billion.

Flood said he expects the development of some national system of paying for health care.

National Prepayment Plan Seen

"Physicians and other providers of health services will increasingly be involved in third party payment systems, and these sytems will tend to be national in scope," he said, but explained that he hesitated to call it "national health insurance." He added, "the widespread acceptance of public and private health insurance plans is causing problems for a "delivery system that is all but incapable of responding to the rising demand."

He said we are locked into a present system which, because there is not enough manpower, is resorting to use of expensive hospital care instead of preventive and ambulatory care, and that this has caused a crisis situation and has sent costs skyrocketing.

The Congressman called for the encouragement of prepaid group practice plans, and greater use of a special kind of allied health personnel to relieve overworked physicians of the more routine procedures—diagnostic work-up, minor procedures, and follow-up care. He said the malpractice problem would have to be solved to make maximum use of this special category of personnel, and that ideally peer review should be carried out by the profession through its state and county medical societies. He predicted the hospital would become the hub for comprehensive health care with emphasis being placed on outpatient, ambulatory care, rather than inpatient services.

He concluded by saying that the present situation is such that only a few of the extremely rich and a few of the destitute are receiving the kind of care that represents the highest achievement of modern medical practice.

He called on doctors to reorganize health services to make this kind of care available to all of the people.

CONGRESSMAN FLOOD is shown in the top photograph. In the center photo, Park M. Horton, M.D., chairman of PMS Board of Trustees, honors Society assistant business manager, M. Robert Sterner, for twenty years of service. In the bottom photo, conference speakers, Donald C. Harrington, M.D. and Matthew Marshall, Jr., M.D., listen to questions at a panel discussion.

Wide Range of Topics Covered

Orlo G. McCoy, M.D., Canton, PMS second vice-president, was general chairman of the Officers' Conference and of the conference committee. PMS President William A. Limberger, M.D., gave the keynote address.

Other members of the Officers' Con-

ferenee Committee, who assisted in the programs and panel discussions were: John H. Boal, M.D., Beaver; David S. Cristol, M.D., Philadelphia; David W. Kline, M.D., Greenville; Claude E. Nichols, M.D., Harrisburg and David J. Keek, M.D., Fairview.

"Health Care Planning in Canada" was the subject of Lloyd C. Grisdale, M.D., Alberta, chairman of the Board of Directors of the Canadian Medical Association. He appeared on a panel on national health care plans.

On the same panel was George Dunlop, M.D., chairman of the board of Massachusetts Blue Shield, who said the type of health care plan adopted would not be as important as the cost controls built into it. Horace Cotton, head of a management consultant firm discussed the British system, and called it "impractical for the U.S."

Medical Care Foundations Explained

The history of medical care foundations was presented by Donald C. Harrington, M.D., medical director of the Foundation for Medical Care of San Joaquin County, established by the San Joaquin Medical Society in 1954 as the first such pre-paid group practice plan founded by a medical society. The foundation has grown to cover twenty-two counties and over 1.5 million people.

He outlined the mechanism of the foundation, and the reasons it was begun.

Necessary Ingredients

He said, " A system of care must have certain ingredients in order to produce the kind of medical care demanded by our citizens in the 1970's. Those ingredients include:

1. Easy access to the system;

2. A price tag that is related to other services in the community and affordable by individuals, groups, and agencies of the government;

3. Comprehensiveness of coverage, including early diagnosis of disease, preventive medicine with a very small p, and continuity of care, with marked capitals;

4. Utilization of existing health care modalities and organizations of new ones;

5. Ability to work with the community at the community level with all voluntary and governmental agents relating to health care.

The foundation for medical care system contains these ingredients."

Matthew Marshall, M.D., Pittsburgh, chairman of the PMS Subcommittee on Medical Care Foundation of the Council on Medical Service, outlined progress made on the Pennsylvania Medical Care Foundation. The full text of his remarks appear on page 15.

Education Explored

Norman S. Stearns, M.D., director of the Postgraduate Medical Institute of Boston; Robert L. Evans, M.D., vice-president for medical affairs of York Hospital; John H. Moyer, M.D., chairman of the Department of Medicine at Hahnemann Medical College; and Rutledge Howard, M.D., appeared on panels concerning the proposed continuing education requirements of the Pennsylvania Medical Society and the PMS Continuing Education Institute. Details on the proposed requirements as they presently exist will appear in the July issue of PENNSYLVANIA MEDICINE. The foundation will be the subject of a paper in a future issue.

The Walter Donaldson Awards for radio and television were presented during Officers' Conference as reported in the May issue of PENNSYLVANIA MEDICINE.

Michael L. Greenwald of WITF-TV, on the left, receives a Walter F. Donaldson radio-television award from William A. Limberger, M.D., PMS president. He accepted on behalf of the public television station in Pittsburgh, WQED, which produced the series on drug abuse, "The Turned-On Crisis." Below are other winners of the award: Fred Williams, WAHT, Lebanon, top left; William Shepherd, WSBA-TV, York, top right; E. David Berlin, WSBA-TV, York, center; Joseph H. Rainey, WDAS, Philadelphia, bottom left, and Ian K. Harrower, WFIL-TV, Philadelphia, bottom right.

Progress Report

The Pennsylvania Medical Care Foundation

MATTHEW MARSHALL, JR., M.D., CHAIRMAN
Subcommittee on Medical Care Foundation

Presented at the 1971 PMS Officers' Conference

The first medical care foundation was established in 1954 in California. In subsequent years, twenty-three medical care foundations were organized by county medical societies in California, as an outgrowth of public demand for comprehensive, prepaid health care benefits and because of the public's growing concern of the total cost of prepaid health care and the manner in which their health care dollars were being spent.

Foundations are an alternative health care financing plan developed by medical societies. All physicians who are willing and able to assume part of the underwriting risk and who are willing to abide by the standards of practice and fees set by their peers are eligible for membership and most have joined. Patients have the yearly option of choosing the foundation rather than a community wide plan. They have a broad based choice of participating physicians, hospitals, and have comprehensive benefits, but they are limited by medically determined standards regarding hospital admission policies, length of stay, and ambulatory services.

Such plans have had a marked effect on costs of hospitalization as reflected by the reduced number of hospital days used by their subscribers.

Physicians in Pennsylvania are aware of the rapidly rising cost of hospitalization. In contrast to physician fees under the Blue Shield Prevailing Fee Plan which in the past two years have been rising at a rate of approximately 6 percent with a 5 percent increase in premium required, Blue Cross increases have been much higher. This is true in government plans as well. For example, Pennsylvania Medicaid costs for hospitalization are said to have risen about 50 percent last year while the increase in case load was only 12 percent. On the other hand, benefit payments under Part B of Medicare in Pennsylvania were only $7.50 for each Medicare beneficiary compared to the $10.60 premium rate. This means that $3.00 of each premium paid by Social Security beneficiaries in Pennsylvania goes to physician care for beneficiaries outside of Pennsylvania.

While we have been effective in developing programs to assure proper use of health care dollars, the current crisis in financing is of such a nature that an innovative statewide effort is needed to meet this challenge. As physicians, we most affect the rate of hospitalization and many of its costs and, therefore, have the most responsibility to take the initiative in developing this approach.

In recognizing the present problems of financing health care, the 1970 PMS House of Delegates approved, in principle, conceptual guidelines for a Pennsylvania Medical Care Foundation and directed the Council on Medical Service to develop a plan for consideration by the 1971 House of Delegates.

The following Developmental Guidelines, prepared by the council's Subcommittee on Medical Care Foundation, generally outline the basic elements of the proposed Foundation for Medical Care:

Purpose and Objectives

One of the primary objectives of the foundation is to provide an alternative means of financing health care at a cost reasonable to both patient and physician.

The foundation is designed to assume the responsibility for the cost and quality control of the health care benefit provisions of its plan. The Foundation intends to carry out this responsibility by expanding or supplementing the cost control mechanisms and underwriting techniques presently utilized by Blue Cross, Blue Shield, and commercial insurance companies in order to meet the requirements of the foundation. The foundation is not intended to replace these organizations, but rather will utilize their administrative capability to the extent it is consistent with the objectives and responsibilities of the Foundation. Enrollment will be open to all providers, including physicians and hospitals who are willing to provide and be reimbursed for those covered services in accordance with criteria for quality, efficiency, and cost standards developed by their respective professional peers. The program will be offered to subscribers on a dual choice basis annually.

Organization

One of the most important points favoring the organization of a statewide Medical Care Foundation is to avoid unnecessary fragmentation in organization and administration, utilizing key personnel to maximum effectiveness and to provide coverage over a broader area than would result if individual counties form foundations. It should be recognized, however, that the statewide foundation will be implemented in four or five regions, delegating as much local responsibility as is practical in the areas of administration, peer review, determination of premium rating structure, sales promotion, etc. The development of the foundation on a statewide basis will assure the coordination of effort necessary to make available the benefits of this effort as rapidly as possible to the citizens of Pennsylvania.

Costs of Development

The various organizations and agencies that will ultimately benefit by the Foundation will be considered as sources for developmental funds. Possible organizations and agencies would be statewide professional associations, prepayment plans, commercial insurance companies, U.S. Department of HEW (Public Health Service and SSA Bureau of Health Insurance), Pennsylvania Department of Public Welfare (Medicaid), industrial interests, etc.

Underwriting of Program Benefits

The benefit structure developed by the Foundation could be underwritten for private business through contracts between the foundation and Blue Plans or commercial insurance companies. Likewise, government agencies could contract with the foundation to underwrite the medicare and medicaid programs. The administrative costs of the foundation would be reflected in the premium structure. Premiums would be collected by the foundation, utilizing the resources of Blue Cross and Blue Shield or a commercial insurance company through contracts with these agencies.

In addition, the Foundation could contract with a third party carrier to jointly underwrite a given benefit package. In such an arrangement, participating physicians could assume a portion of the risk of the underwriting responsibility through a prospective pro rata payment procedure.

It is important that the Foundation be flexible enough to accommodate the various underwriting approaches, including prepaid group practice plans meeting the criteria of the Foundation related to quality, efficiency, and cost.

Role and Responsibility

Cooperating Agencies

In addition to fiscal and administrative responsibilities, an essential role of Blue Cross and Blue Shield will be to provide the foundation with those services which will enable or assist the foundation to pay for medical care in accordance with criteria developed by the Pennsylvania Medical Society to assure

the appropriateness and quality of covered services. The expertise developed by Blue Cross and Blue Shield can be of vital importance to the foundation in developing a successful program on a cooperative basis. The Hospital Utilization Project (HUP) can play a significant role in assisting hospitals and physicians in demonstrating their ability to provide health services in accordance with Pennsylvania Medical Society standards. For example, the existence of an HUP program at a hospital can lessen the need for paperwork by the physician and hospital by assisting them in developing the information required by the foundation to assure the proper application of prospective review techniques which will reduce the need for cumbersome written pre-authorization for hospitalization. Furthermore, HUP can assist the hospital medical staff in demonstrating the effectiveness of its utilization review and medical audit programs.

Foundation

The Foundation will assume the following responsibilities in the administration of health care programs:

1. Develop and implement policies and procedures for utilization review and cost control with respect to all benefits provided by the foundation;
2. Coordinate all utilization review and cost control activities of contractual agencies;
3. Develop and maintain criteria, in cooperation with the Pennsylvania Medical Society, for the prospective or retrospective evaluation of medical care in all areas of Pennsylvania with respect to quality and medical necessity;
4. Determine the levels of reimbursement for covered services in the benefit structure;
5. Enter into agreements with physicians, hospitals, and other providers who desire to participate in foundation programs. In addition, the foundation will enter into agreements with employee groups, individual subscribers, or government agencies who may desire to have the foundation underwrite a health services plan.

Benefit Structure

The objective of the foundation is to provide comprehensive benefits, including health maintenance programs, with the emphasis on various out-patient services which are a reasonable alternative to hospitalization. The benefit structure will be dependent upon the ability of the foundation to develop reasonable prepayment criteria for both out-patient and in-patient services. The foundation must be certain that the necessary mechanisms are developed to assure that adequate prospective and retrospective review procedures are in effect to analyze the quality, effectiveness, and appropriateness of care provided. The health care needs, as perceived by subscribers, and the funds available to them to underwrite the benefits will obviously be prime factors in the development of the benefit and premium structure. The premium rating can be set up to accommodate a regional rating structure.

Reimbursement Policy and Procedure

Payments to physicians would be determined by using the usual, customary, and reasonable criteria as set forth in the Blue Shield Prevailing Fee Program. The 90th percentile concept would be used in developing the customary levels. However, payment would be made only for services determined, in accordance with PMS criteria, to be medically necessary, and payment to physicians and hospitals would be continued only so long as would be deemed appropriate by PMS standards, unless the need for additional services was certified by the attending physician subject to review by the hospital utilization review committee and appropriate PMS committee.

Hospitals will receive full reimbursement for essential costs utilizing reimbursement standards developed by committees with expertise in hospital administration.

Advantages of Foundation

Patients

The Foundation is basically a program with full service benefits by participating providers, although co-insurance provisions may or may not be included for both out-patient and in-patient services. It is anticipated an indemnity payment may be made when covered services are provided elsewhere.

The patient will have a maximum of freedom of choice of an anticipated broad base of both participating physicians and hospitals or other institutions. In addition, the projected economies of the foundation program will allow patients to elect broader benefits or conceivably to continue with similar benefits at reduced costs.

Physicians

The foundation allows the physician maximum flexibility in selecting type of practice (solo or group) and the method of reimbursement (fee-for-service, capitation, or salary arrangement with a group). The physician will receive full fee reimbursement based on the usual, customary, and reasonable criteria with reduced paperwork. The participating physician will be assured that policy and procedures will be established by his peers. If profitable, the foundation will offer fiscal incentives for participating physicians to encourage efficiency in a manner as determined by the foundation.

Hospitals

The primary incentive for hospitals to participate will be fiscal in nature. The foundation program will provide hospitals an opportunity to budget their expenditures prospectively in a manner mutually agreed upon by the hospitals and the foundation or agency acting on the foundation's behalf. If profitable, fiscal incentives to encourage efficiency will be offered.

Third Parties

The foundation program will offer an alternative prepaid plan with a centralized, uniform cost control mechanism to third parties and individual subscribers whose objective is to assure quality, efficiency, and economies for their respective benefit.

Peer Review Procedures

Criteria or standards for hospitalization and out-patient services, as developed by the Pennsylvania Medical Society, will be utilized by the foundation on a statewide basis with regional modifications, where appropriate. Deviations from these standards of medical practice will be referred for evaluation and recommendation by the foundation to peer review committees, including hospitalization committees, established by or in cooperation with the Pennsylvania Medical Society and the Pennsylvania Osteopathic Association. The emphasis of the foundation's peer review process will be comprehensive, prospective evaluation designed to avoid the unnecessary utilization of hospitals and physicians' services. The retrospective review and the development of utilization review techniques demonstrating patterns of practice will be used to develop more sophisticated prospective review and to reduce the need for written pre-certification for elective hospital admissions. The expertise developed by Blue Shield, Blue Cross, and HUP, as well as the Pennsylvania Medical Society's Councilor District Review Committees and Specialty Advisory Committees, will be utilized in the development of the standards which will serve as guidelines for determining payments on a prospective basis. The Blue Cross District IV Utilization Review Proposal will be used as a guide in developing hospitalization criteria. A cooperative relationship between the Blue Cross District IV - PMS Committee is anticipated.

Relationship of Foundation with Proposed Professional Standards Review Organizations (PSRO) and Health Maintenance Organizations (HMO)

Since the successful operation of the foundation is dependent on comprehensive, in-depth peer review procedures, it is being designed to meet the requirements necessary to quality as a PSRO consistent with legislation which has passed the U.S. Senate and is endorsed by the Administration.

It is also anticipated that the foundation will be developed consistent with the objectives of a Health Maintenance Organization.

Newspapermen receive PMS Donaldson Awards

PMS President William A. Limberger, M.D., has announced that the Society's Walter Donaldson Awards for newspaper reporting in the fields of medicine and health have been awarded to David M. Cleary of the Philadelphia Bulletin and the team of Robert V. McCarthy and Patrick J. Boyle of Dardanell Publications, based in Monroeville. Winners received the prizes— plaques and $100— at the Pennsylvania Press Conference in Harrisburg May 14.

The winning entry by Cleary described how and why he donated his body to medical science. It appeared in the Evening Bulletin of Oct. 16, 1970. The judges cited him for "clear, fascinating first-person reporting on a subject of great potential health benefit to the public."

The team of McCarthy and Boyle won for a series of articles and editorials on the abortion question in the state. The series appeared in Dardanell Publications in September, 1970. The judges called the series "an outstanding example of a well-researched, well-written presentation to meet a crucial public need to understand a controversial health and social issue."

The newspaper award judges were Clement J. Sweet, news editor of the Sunday Patriot-News, Harrisburg; Richard A. Swank, publisher of the Duncannon Record; and Dr. David A. Smith of Harrisburg, medical editor of the state medical society's monthly magazine, PENNSYLVANIA MEDICINE.

DONALDSON AWARDS winners in the newswriting field received their awards at the Pennsylvania Press Conference May 14 in Harrisburg. Above, left to right, are Edward T. Lis, M.D., York, PMS fourth vice-president, presenting awards to David M. Cleary of the Philadelphia Bulletin and to Robert McCarthy and Patrick Boyle of Dardanell Publications, Monroeville.

Self-evaluation test offered to physicians

The Education Committee, together with a special committee of society members of the Philadelphia County Medical Society, has prepared an examination in the form of a ninety-six page booklet for self-evaluation designed to help physicians identify any areas of deficiency. As an aid to assisting doctors in upgrading their knowledge, questions were contributed by thirty-five physicians from the five Philadelphia medical colleges. The fee for the examination and accompanying bibliography is $5.00. Write: Philadelphia Medical Society, 2100 Spring Garden St., Philadelphia.

M.D. golf meet set

H. Keith Fischer, M.D., Philadelphia, has announced that the fifty-fifth annual tournament of the American Medical Golf Association (AMGA) will be held at the Seaview Country Club on Monday, June 21, 1971, at the time of the AMA convention. Information may be obtained through Theodore A. Henderson, M.D., AMGA secretary-treasurer, 500 Willow Ave., Ambler, Pa. 19002. The local advisor for AMGA is James S. McLaughlin, M.D., Philadelphia. Committee Members include A. Reynolds Crane, M.D., Philadelphia; Theodore A. Henderson, M.D., Ambler; and Frederick P. Sutliff, M.D., Philadelphia.

Jefferson - PSU five-year program evaluated

A conference was recently held at Jefferson Medical College to evaluate the five-year combined college and medical school program initiated in 1963 and jointly sponsored by Jefferson Medical College and Pennsylvania State University. Nearly 100 students have received their Doctor of Medicine degree under the program to date.

Dr. Clarence Noll, dean of the PSU College of Science, reported that (1) the program has attracted large numbers of exceptional students, (2) the program is producing physicians of superior maturity and skill, (3) the time required and the cost of education have been reduced, and (4) the result is that good students who otherwise would have gone into other fields because of the pressure of time and money are becoming physicians.

William F. Kellow, M.D., dean of Jefferson Medical College, believes that by using advanced placement testing and by revising the undergraduate curricula, the program can be further improved.

Pilots to get emergency training

The Pennsylvania Department of Education is conducting a second medical program for state police helicopter pilots June 1 to June 4 at the Polyclinic Hospital, Harrisburg. Films will be shown, and lectures on a variety of medical emergencies will be delivered by Drs. Lewis T. Patterson, Alphonse Edmundowicz, William Silvernail, Robert Gilroy, Joseph Garfunkel, Joseph McGrath, William DeMuth, James Yates, and Champe C. Pool, all from the Harrisburg area.

MEDICAL EDUCATION ADMINISTRATION was the theme of a recent conference in Hershey sponsored by the PMS Council on Education and Science. Two of the speakers were C.H. William Ruhe, M.D., Chicago, director of the AMA's Medical Education Division, shown speaking in the first photograph below, and Robert L. Evans, M.D., vice-president of medical affairs at York Hospital, The two other photographs are scenes from the conference workshops.

Electronic workers'deaths under investigation

The State Environmental Resources Department (PDER) has reported an investigation in cooperation with a Pennsylvania electronics firm about possible danger from low energy electromagnetic radiation similar to that sensed by a TV antenna. Two male workers (ages 38 and 42) engaged in a federal electronics project died last year of astrocytoma.

Both the State Occupational Health and the federal Defense Departments have been closely checking engineers and technicians working on the project.

Thirteen of the twenty-three original employees remain on the project after ten years, one of whom is experieneing symptoms.

Allegheny physicians urged to meet needs of people

The 2,000 physician members of the Allegheny County Medical Society were urged recently— in a personal letter from Society President Fred C. Brady, M.D., and an editorial in the organization's *Bulletin*— to share the responsibility for treating welfare patients and to press for improved conditions in out-patient clinics and emergency rooms.

Urging members to "give care— with dignity— to the sick, rich and poor alike," Dr. Brady implored the physicians "to accept and treat discreetly, out of a sense of moral obligation, those patients who cannot pay their own way, and to cope with the accompanying paper work, which— in this era of bureaucracy— we must face daily in other contexts."

"Relegating welfare patients to specific hours on specific days adds humiliation to the burden of poverty and illness they already bear," he said.

In an editorial entitled "Crisis at Home" in the *Bulletin*, Associate Editor Ralph C. Wilde, M.D., acknowledged the "major problems" recently brought to the attention of the society's Board of Directors by the Welfare Rights Organization of Allegheny County (WROAC): the refusal by some physicians to see welfare patients at all or, in some cases, acceptance only on a limited basis, and long waiting periods for appointments and for care, both in physicians' offices and clinics.

"From a practical standpoint," he warns, "some of these problems will not be solved until our state and federal governments come up with the necessary dollars to provide a realistic program for the management of welfare recipients."

Meanwhile, however, he suggests, one approach to the problem would be to "streamline and update our hospital out-patient clinics and emergency rooms, (converting) them into ambulatory care centers in the true sense of the word."

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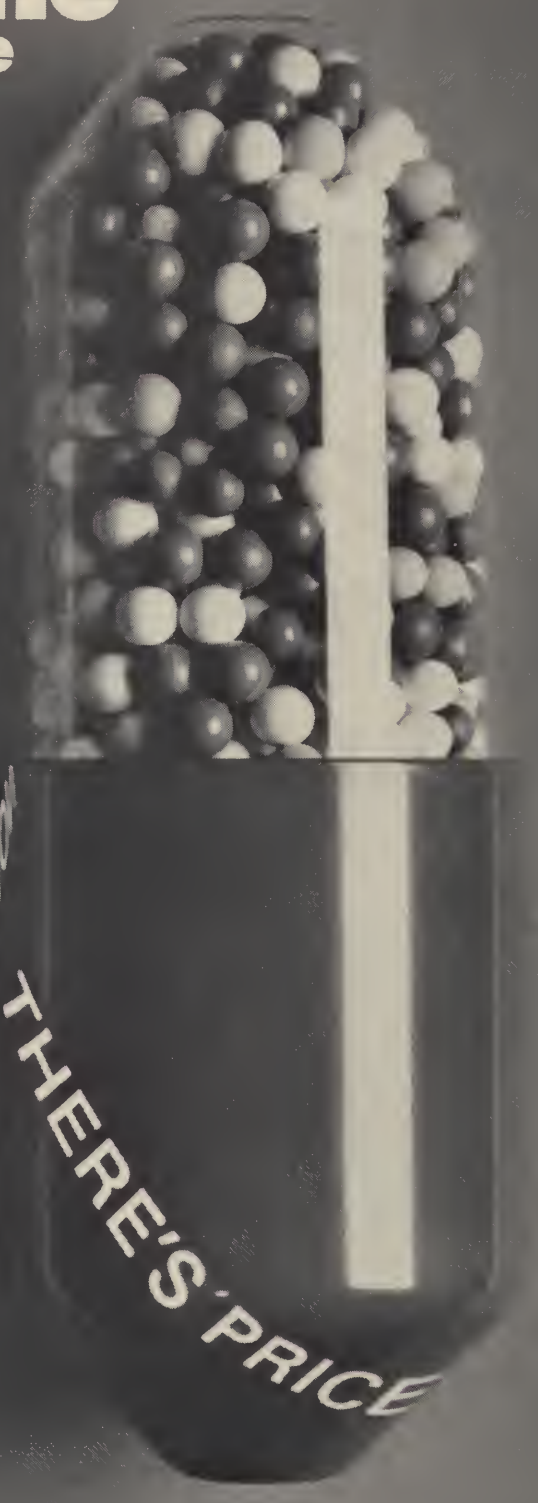

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due to androgenic deficiency in the American male.
The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

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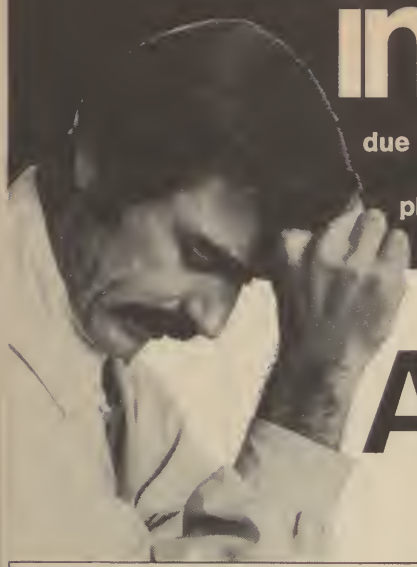
The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



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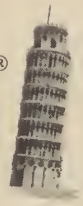

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Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

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Thiamine HCL .....10 mg.
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Bottles of 100, 500, 1000.

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Each orange tablet contains:
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Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
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Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
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Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
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Riboflavin .....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangelisie, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Heilman, L., Bradlow, H. L., Zumeff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Warshub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

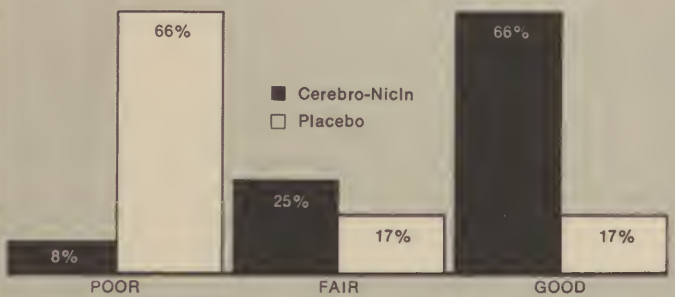
Write for literature and samples: BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West 6th Street, Los Angeles, California 90057

For the treatment of the aging patient

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir 8 oz. bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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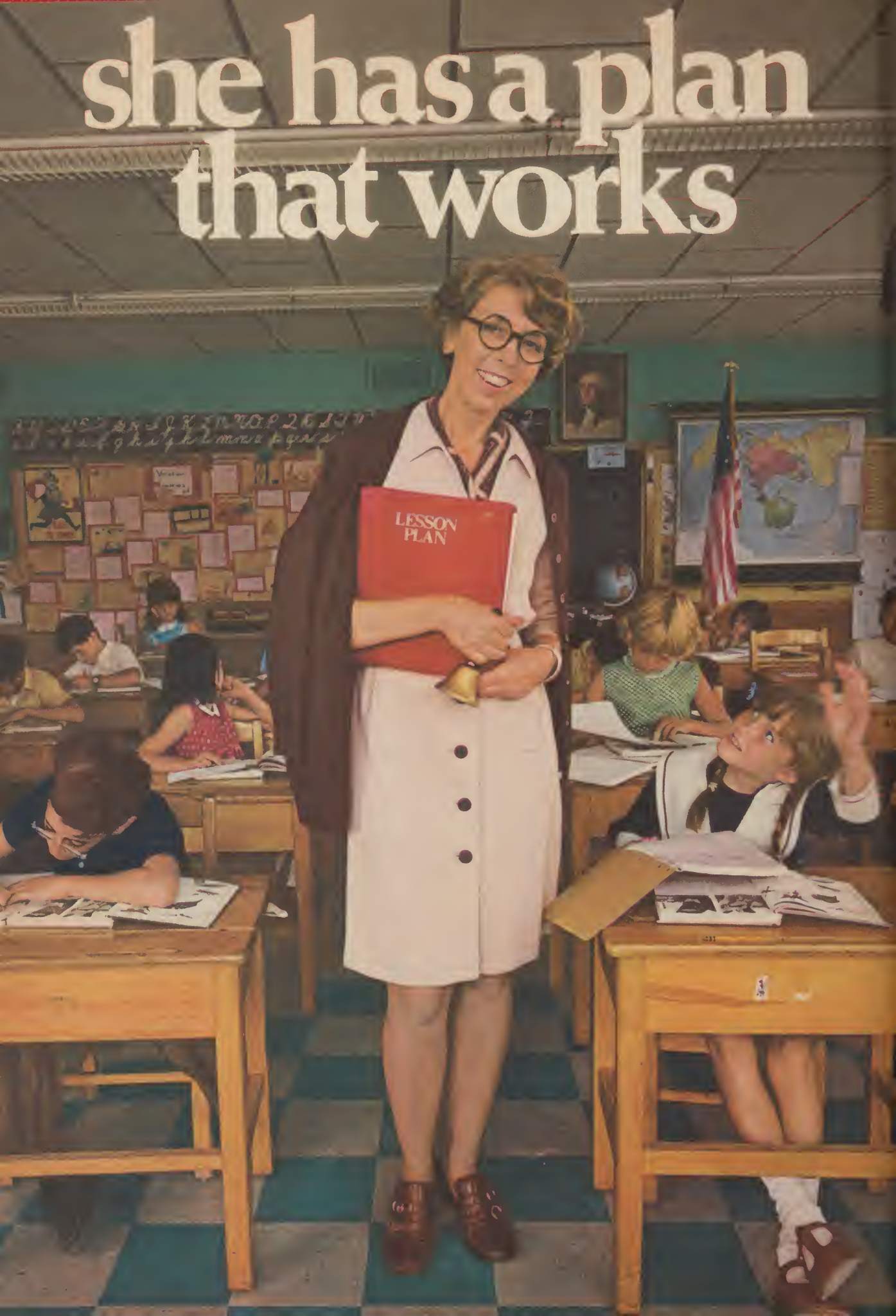
she has a plan
that works
LESSON
PLAN

She has a plan that works.

She has one plan for the class. And they really respond.

She has another plan just for herself. A medication plan for her hypertension. And she's also responding beautifully.

More than just another antihypertensive, Ser-Ap-Es can be a whole medication plan for living with hypertension.

Does it get good marks for comfort?

Excellent. Because Ser-Ap-Es controls blood pressure effectively, dosage of each component is lower than if prescribed alone, usually minimizing side effects. However, side effects may occur (see prescribing information).

Designed with the kidney in mind?

Hydralazine maintains or increases renal blood flow.

And the brain too?

Hydralazine also relaxes cerebral vascular tone. And reserpine has beneficial calming action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

Practical on a teacher's salary?

Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits…

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

C I B A

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

a plan for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

INDICATIONS: All cases of hypertension except the mildest and the most severe.

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

Hydralazine: Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Reserpine: The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydralazine: Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

Hydralazine: Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Reserpine: Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

Hydralazine: Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE: One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

SUPPLIED: *Tablets* (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Summit, New Jersey

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she has a plan that works for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

CIBA

In December of 1969, the Student American Medical Association (SAMA) received a grant from the Sears Foundation to establish a national program of preclinical fellowships in community hospitals. It was named the Medical Education-Community Orientation Program (MECO). The objective of the program was to use medical students' vacation time to gain an insight into primary health care outside the medical school's facilities. This program is national in scope, with each state planning and directing its own program. The SAMA office contributes administrative, secretarial, and financial aid where needed.

During the summer of 1970, a pilot medical and community education program was initiated at the University of Pittsburgh entitled "The University of Pittsburgh Summer Preceptorship Program." An evaluation at the end of the summer convinced the planners that their experience would be valuable to the national program, and a decision was made to affiliate with MECO.

As a result, a 1971 MECO program is currently being organized, endorsed by the PMS, the Hospital Association of Pennsylvania, the State Board of Medical Education and Licensure, and the Pennsylvania Academy of General Practice.

The story of the pilot Pittsburgh Summer Preceptorship Program follows:

Medical students head for the hills

ROSS E. WILLIAMS, CHAIRMAN
Preceptorship Program Planning Committee
Pittsburgh

In the summer of 1969, two first-year University of Pittsburgh medical students participated in SAMA's Appalachian Student Health Project, a nine-week summer preceptorship spent with a physician in an Appalachian community. The experience impressed them with the potential for motivation and personal growth inherent in this type of educational experience. They decided, therefore, to develop a similar program in their own medical school.

It was hoped that such a preceptorship program would motivate participants to pursue careers in primary health care in inadequately served communities.

Program Planning and Development

Student interest was solicited through a questionnaire distributed to first and second year classes. Faculty and community physician advisers were selected and they, together with seven students, formed the Planning Committee, composed of Robert J Carroll, M.D., past president of Allegheny County Medical Society; Barry Kraynack, PMS I; Thomas C. Long, PMS I, Project Director; John B. Martin, PMS II, Treasurer; David Reed, M.D., assistant director of Western Pennsylvania Regional Medical Program; James E. Richey, PMS II; Kenneth D. Rogers, M.D., professor and chairman of the department of community medicine, University of Pittsburgh School of Medicine; Jack Smith, PMS I; Ken Wiant, PMS II; Ross E. Williams, PMS II, committee chairman; Larry Wingard, PMS I. (PMS indicates University of Pittsburgh medical student.)

The Committee studied the experience of other schools with preceptor programs, developed program objectives, explored funding sources, developed program content, and constructed evaluation procedures.

Program Objectives

The program objectives were to:

(1) Provide a rewarding summer experience in medicine for first and second year medical students at the University of Pittsburgh;
(2) Expose medical students to primary health care delivery outside the University Medical Center;
(3) Enable students to relate different aspects of hospital operation to specific patients;
(4) Stimulate an awareness of comprehensive community health;
(5) Enable students to determine their career goals and to better plan their medical education;
(6) Reinforce learning in the preclinical years of medical school by relating specific information to clinical medicine;
(7) Increase the practicing physician's awareness of the problems and needs of medical students, and conversely, to develop in the student an appreciation of the problems faced by the practicing physician.

Financing

The initial questionnaire exploring first and second year medical student interest asked whether students would participate in the summer preceptorship program if no pay were provided. Of forty-six interested students, only five stated they definitely would participate without pay. The committee selected $600 as a reasonable stipend for the summer preceptorship, the same amount offered by the School of Medicine for student summer research work. A number of funding sources were investigated and found unavailable for the program. Support eventually came from individual hospitals to which students were attached. However, because of their source and accompanying commitments, this funding shifted program emphasis from physician and community to hospital.

Development of Program Content

The model program developed by the planning committee for participating hospitals suggested that students spend approximately two-fifths of their time in the hospital (hospital rounds, emergency room, laboratory, administration, surgery, etc.); two-fifths in the office of primary care physicians (general practitioner, internist, pediatrician); and one-fifth observing other community services (public health, environmental control, anti-poverty programs, etc.). Each student also was to have a single preceptor (a physician with a family-based practice) responsible for helping him plan and coordinate his activities for the entire summer. Interested hospitals were identified by their response to an introductory letter sent to hospital administrators through the Hospital Council of Western Pennsylvania. Each interested hospital received further information from the planning committee including the suggested model program. Over twenty hospitals submitted preliminary programs to the planning committee, and 22 first- and second-year medical students were then assigned to 12 participating hospitals* of their selection. Lack of knowledge about non-urban community hospitals probably influenced the selection of urban hospitals in some instances.

Evaluation Procedures

Several procedures were developed to evaluate the effectiveness of the program. Attitude questionnaires were completed before and after the summer by the 22 participants and by a control group of 30 non-participants. All preceptors also received student and program evaluation forms at the end of the summer. Students submitted weekly progress reports and a participant discussion was held in September.

Program Evaluation

A comparison of attitudes and career plans before and after the preceptorship did not disclose marked differences. However, before the preceptorship the 22 participants and their 30 non-participating classmates answered the questionnaires quite similarly. Afterwards, however, participants expressed greater appreciation for the role and competence of the family practitioner, a greater interest in a clerkship in family practice, and a greater interest in group and rural small town practice than did non-participants who had spent their summer in some other way.

The following written comments of participants describe changes in attitudes and interests.

"I am definitely more interested in general practice."

"Confirmed my plans to enter family practice."

"Dr. X is one of the finest people I've met. At this time, I emulate him to a great extent. He is and does exactly what I hope to be and do some day."

"I want to take a family practice clerkship in the fourth year."

"This summer turned me on to medicine. Was depressed after the first year of basic science."

"My best week was that spent with two GP's. I had a bad opinion of GP's before, and I was really impressed."

Achievement of Program Objectives

Each participant was given a list of the seven program objectives and asked to rate on a five point scale the extent

Participating hospitals were: Allegheny Valley, Armstrong County Memorial, Braddock General, Butler County Memorial, Columbia, Conemaugh Valley Memorial, Latrobe Area, Oil City, St. John's, St. Margaret's, Shadyside, Washington.

Students comment . . .

"General exposure to practice and hospital setting helped make preclinical courses 'come alive.' "

"I now have a better idea of a career choice and plan to practice in a smaller community."

"This program was without a doubt the most worthwhile experience of my first year."

"I can't imagine anything I would rather have done for the summer."

"You can get as much out of the program as you want to."

"Excellent opportunity to get first view of clinical medicine— presented in perfect fashion to one just finishing his first year."

to which they were achieved in his summer program (1 = not achieved ... 5 = completely achieved). The average response for each objective is as follows:

Objective	Average Score
1. Rewarding summer experience	4.3
2. Learn primary health care	4.4
3. Learn aspects of hospital operation	3.9
4. Increase awareness of community health	3.4
5. Better plan career and education	3.9
6. Reinforce preclinical learning	3.6
7. Appreciate practicing physician problems	3.6

Preceptorship Content

Students stated that they spent their time as follows: physician's office 26 percent, hospital 65 percent, and elsewhere 9 percent. A list of 37 activities was prepared in which the student might have participated during his preceptorship. Students were asked to note for each of these whether they had participated in them, only observed them, or neither participated nor observed. Students reported observation or participation predominantly with in-hospital services and clinical functions. Many had little or no exposure to community services such as public health nursing, social work, anti-poverty programs, etc.

Students who reported participation in the largest number of activities appeared to be the most satisfied. The passive-observer role was least desired, and all but one of the twenty-two students expressed a wish for more active involvement.

When problems occurred in the preceptorship, the cause largely was lack of experience. Students often lacked skills (e.g. taking blood pressure, use of instruments, physical diagnostic techniques) which would allow them to participate actively in meaningful educational experiences.

The lack of student participation in community health activities was disappointing to the planners of the program. Possible explanations include the preference of participants for direct clinical experience, the strong hospital orientation of the program, and the failure of the planning committee to convey effectively to preceptors and students the community health objective of the program.

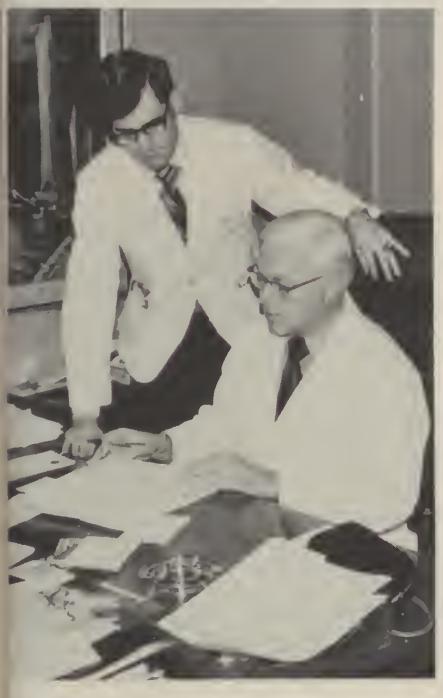
Twenty of twenty-two students stated they would like to participate in a similar program another summer. Student comments about their experience conveyed both interest and satisfaction.

Evaluation by Physicians

Over 80 percent of preceptor evaluation questionnaires were returned. Preceptors reported that students were well accepted by physicians, nurses, technicians, and administrators. Patient acceptance, on the whole, was reported as excellent in most cases. Most doctors stated a preference for post-sophomore students and objected to pre-freshman participation.

Overall, the first year's summer preceptorship program was considered to have achieved its goals. The planning committee concluded that the program should be offered again in 1971 and that it should be expanded and developed to include opportunities for a larger number of students, preceptors, participating hospitals and communities. The committee noted especially the desirability of a multi-level program offering different educational programs specially suited for pre-freshman, post-freshman and post-sophomore medical students. In future years it may be feasible and desirable to develop an interdisciplinary project-oriented program for students in the schools of medicine, nursing, dentistry, public health, pharmacy, law and social work.

In future programs special efforts will be made to prepare students with basic skills, orient students and preceptors more effectively regarding the objectives of the program, and maintain closer liaison with both participants and preceptors throughout the summer program.



Postscript

The Pennsylvania MECO program for 1971 will be a continuation of last year's program with innovations. Thomas C. Long, University of Pittsburgh, will act as state project director and will coordinate the activities of two planning committees with those of the four endorsing organizations. Ross E. Williams, University of Pittsburgh, will be chairman of the Western Pennsylvania Planning Committee which will recruit students from the University of Pittsburgh and seek placement of students in the western region. Henry Mishel, Hahnemann, will be chairman of the Eastern Pennsylvania Planning Committee, comprising representatives from the six medical schools in the eastern part of the state.

Forms, to be screened by the planning committees, are being sent to hospitals. The names of potential preceptors, the availability of living accommodations, and a brief description of personnel and facilities, are the kinds of information required. Lists of interested students will then be matched with replies. A stipend of $600 for the summer together with room and board, if possible, are requested.

Additional information regarding definitive objectives, guidelines, information regarding stipends, model programs, and possible hospital and community activities may be obtained by contacting the Council on Education and Science, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, Pa. 17043.

PMS rotogravure

THE COMMITTEE *on Emergency Medical Services of the State Society spent many hours in sessions at Society Headquarters preparing its report on emergency medical services in Pennsylvania. Shown here are some of the members of the committee during a luncheon recess. Committee Chairman William F. Bouzarth, M.D., Philadelphia, is in the center of the top photograph.*

"INTERESTED, INFORMED, INVOLVED"... this was the theme of the annual mid-year conference of the Woman's Auxiliary to the Pennsylvania Medical Society. The words serve also to describe the members as they tackle their projects. The conference was highlighted by a forum on alcohol in relation to highway safety called "Everybody's Problem." Below are scenes from the conference. In the photograph on the left Mrs. Hugh M. Crumay, conference chairman, greets Mrs. Ralph S. Blasiole, president-elect, far right, as J. Thomas Millington, M.D., chairman of the PMS Advisory Committee to the Auxiliary, and Mrs. Hiram E. Armstrong, conference co-chairman, look on. In the photograph on the right, Mrs. Paul Budura, chairman of the Safety-Disaster Preparedness Committee of the auxiliary, discusses the forum with two of the speakers: Jasper G. Chen See, M.D., director of Quality Control Medical Laboratories, and Mr. Edmund R. Ricker, chief of the hazardous substances transportation board of Penndot.

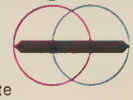
THE YORK COUNTY Medical Society recently came to Society Headquarters in Lemoyne for a dinner meeting. Shown below are members and their wives. To the left, Arthur C. Crovatto, M.D., county society program chairman, is at the rostrum introducing John F. Rineman, PMS executive director, seated, who explained the functions of the State Society.

psychic stress and somatic symptoms

The intertwining of psychic stress and somatic symptoms often confuses and distorts the patient's clinical profile. Sinequan (doxepin HCl) can help clarify the origin of somatic symptoms by relieving the causative, or accompanying, psychoneurotic anxiety and depression.

Sinequan®
DOXEPIN HCl

Starting dosage:
25 mg. t.i.d.
for mild to moderate
symptomatology



The tranquilizer that is an antidepressant. The antidepressant that is a tranquilizer.

BRIEF SUMMARY
Sinequan (doxepin HCl) **Capsules**
Contraindications. Sinequan (doxepin HCl) is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan (doxepin HCl) is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan (doxepin HCl) has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan (doxepin HCl) in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan (doxepin HCl). The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan (doxepin HCl) has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan (doxepin HCl), however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan (doxepin HCl) can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan (doxepin HCl) does exert a significant blocking effect. In addition, Sinequan (doxepin HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Sinequan (doxepin HCl) is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., and 50 mg. of doxepin in bottles of 100; and 25 mg. and 50 mg. in bottles of 1000.

More detailed professional information available on request.

Pfizer **LABORATORIES DIVISION**
PFIZER INC., NEW YORK, N.Y. 10017

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m.d.'s in the news

TEMPLE UNIVERSITY'S founder's dinner was the occasion when Paul R. Anderson (left), president of the Temple University , presented John A. Kirkpatrick, M.D., (right) with the alumni Certificate of Honor for service to the School of Medicine alumni association. Dr. Kirkpatrick is director of the department of radiology at St. Christopher's Hospital for Children, professor of radiology at Temple's School of Medicine, president of the faculty senate at the medical school, and a member of the hospital's board of managers.

A number of new hospital appointments have been announced. Mercy Catholic Medical Center, Upper Darby, announced the staff additions of **Arthur S. Haber, M.D.**, Broomall, and **Mary Elizabeth Jeffery, M.D.**, Upper Darby, radiology; **Stephen Kratzinger, M.D.**, Drexel Hill, surgery; **Alfred DiGiacomo, M.D.**, Upper Darby, obstetrics and gynecology; and **Ralph A. Rossi, M.D.**, Drexel Hill, honorary staff.

Somerset Community Hospital has appointed **Harold E. Musser, Jr., M.D.**, to the associate staff.

Anthony Kales, M.D., of Los Angeles, an internationally recognized authority on the diagnosis and treatment of sleep disturbances, has been named professor and chairman of psychiatry at the Pennsylvania University College of Medicine, Hershey. Dr. Kales is currently professor of psychiatry, director of the sleep research and treatment facility, and a member of the brain research institute at the University of California in Los Angeles.

The three first physicians in the nation to receive plaques from the American Board of Family Practice after completing a series of exams are **Thomas Patrick, M.D.**, Mifflinville, **Michael Daly, M.D.**, Danville, and **D. Ernest Witt, M.D.**, Bloomsburg.

Samuel W. Deisher, M.D., obstetrician and gynecologist, has been named chairman for the 1971-72 United Fund campaign of the United Community Services of York County. **Daniel M. Friday, M.D.,** also an obstetrician and gynecologist, has accepted the chairmanship of the professional division of Tyrone's $150,000 "New Jobs For Joes" fund drive. This fund is for the purpose of providing jobs for the unemployed in the Tyrone area.

Minerva S. Buerk, M.D., Bryn Mawr, president of the American Medical Women's association, has been honored as one of six "distinguished American women" by the government of France. She will be a guest of the French government from April 23 to May 6, 1971 on a two-week tour.

Dr. Buerk served as chief of dermatology at the Bryn Mawr Hospital from 1958-1969 and became consultant in dermatology at the hospital in 1970. She is on the teaching staffs at the University of Pennsylvania and the Medical College of Pennsylvania. She also conducts a private practice in dermatology.

Dr. Buerk believes the medical profession is now in a state of flux which could provide more opportunities for women in the future. She has stated that "The medical profession is changing its image and is making the changes fast because we need doctors." Dr. Buerk said, "The American Medical Women's Association relies on counseling to get more women into the medical field." She listed pediatrics, general medicine, gynecology, dermatology, psychiatry and anesthesiology as good medical fields for women. She also said "Medicine is a very demanding career, but it's also one of the most gratifying, both intellectually and emotionally. That's why it's a natural for women!"

Marvin M. Malcotti, M.D., Pottstown, has been appointed acting deputy superintendent of the Pennhurst State School and Hospital, Spring City. Formerly a research psychologist and director of research at Pennhurst, he is also currently adjunct professor of psychology at Penn State University.

The University of Pittsburgh School of Medicine has recently announced three new appointees to its faculty. **Andrew Dekker, M.D.,** who holds a pathology staff appointment at Presbyterian University Hospital and the Eye and Ear Hospital, has been appointed associate professor of clinical pathology. **Hernando Salazar, M.D.,** a staff member at Magee-Women's Hospital, is now associate professor in pathology. In addition, **Robert H. McDonald Jr., M.D.** will serve as associate professor of medicine and associate professor of pharmacology.

Formerly an instructor in plastic surgery, a fellow of the Harrison Department of Surgical Research, an associate in plastic surgery at the Graduate Hospital of the University of Pennsylvania, and director of the tumor clinic at the Graduate Hospital, **William P. Graham, III, M.D.,** has been appointed associate professor of surgery and chief of the division of plastic surgery at the Milton S. Hershey Medical Center in Hershey.

Fifty-year plaques were presented to eight Schuylkill County doctors by John F. Rineman, executive director of the Pennsylvania Medical Society. They include Drs. **Russell Sweeney,** Allentown, **William J. O'Neill,** Ashland, **M. O. Blechschmidt,** Cressona, **Guy Bashore,** Minersville, **William Leach,** Shenandoah, **Walter Luchinsky,** Mahanoy City, **William Dorasavage,** and **William Cress,** Pottsville. In Erie County, **Russell Anderson, M.D.,** author of a recent article, "Medicine in George Washington's Time," also received a 50-year plaque.

The Alumni Association of St. Joseph's College, Philadelphia, has honored **Edward J. Kowalewski, M.D.,** Rothville, with the 1971 Shaf-

(Continued on Page 35)

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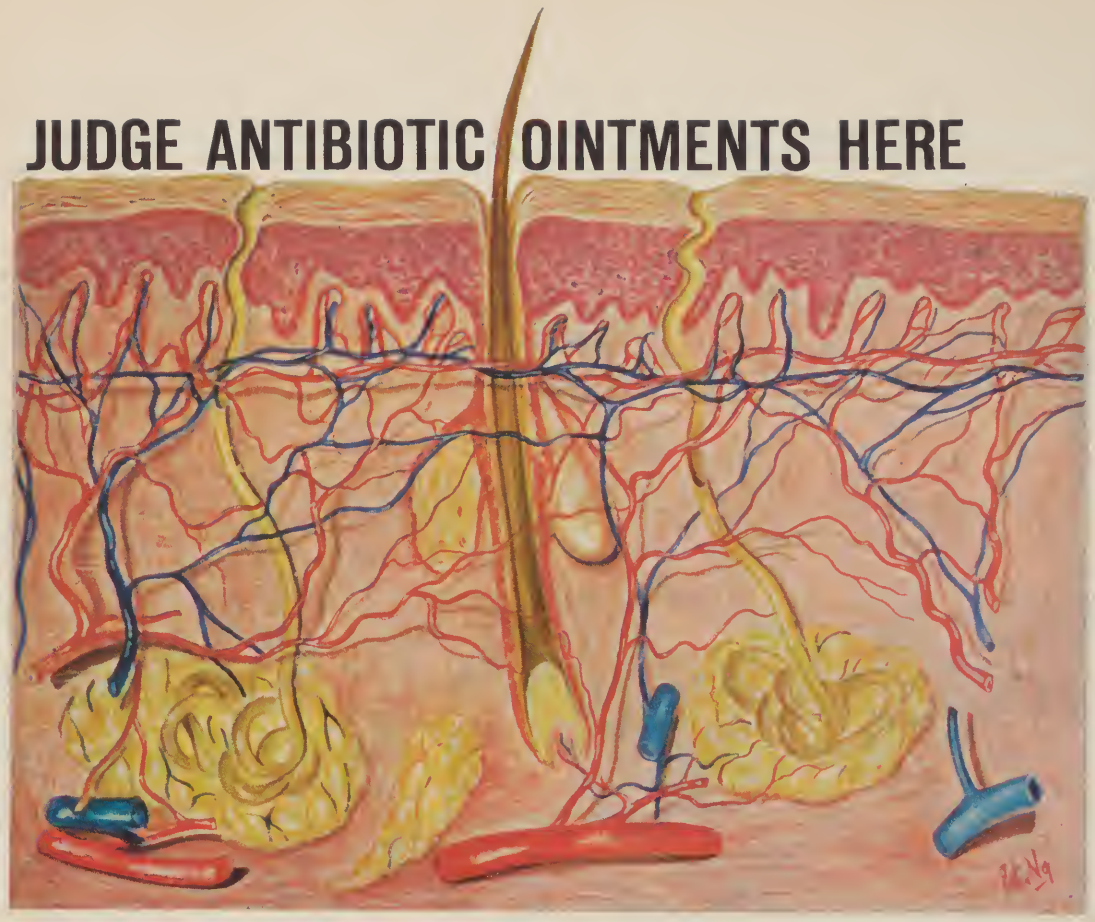

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m.d.'s in the news *(continued from Page 30)*

frey Award in recognition of years of outstanding service. Dr. Kowalewski, now practicing in Akron, O., is the immediate past president of the American Academy of General Practice, currently serving as a member of the board of directors.

Mayer A. Green, M.D., Pittsburgh, will serve as the chairman of the newly organized Allergy Section Council of the American Medical Association.

The Department of Welfare has announced the appointment of **Robert F. Babskie, M.D.,** Nanticoke, as acting regional director for Mental Health and Mental Retardation. He will serve in conjunction with his duties as Superintendent of Retreat State Hospital.

Ralph Snyder, M.D., Ambler, has been nominated second vice-president of the Pennsylvania Health Council. **George Bender, M.D.,** Chester County Health Department, and Mrs. Leroy Gehris of the PMS Woman's Auxiliary have been nominated as members-at-large.

The Distinguished Service Award of the Academy of Allergy has been presented to **Sheldon G. Cohen, M.D.** of Wilkes-Barre at the annual meeting of the AAA. Dr. Cohen has been general chairman of the Research Council, advisory board member, and historian of the academy.

Appointments of interest include that of **Carl W. Gatter, M.D.,** who has been named acting director of the Mayview Community Services Center in Pittsburgh.

John Silverio, M.D., has been appointed associate director of medical communications of Wyeth Laboratories where he will conduct clinical studies on infant and other nutritional products, and will assist in the review of labeling and advertising of products. He is a fellow of the American Academy of Pediatrics and of the College of Physicians of Philadelphia. He is also an associate in pediatrics at the University of Pennsylvania School of Medicine, a member of the American Therapeutic Society, the American Society of Microbiology, and the American Medical Association.

DR. SILVERIO

DR. SODEMAN

William A. Sodeman, M.D., former dean of Jefferson Medical College in Philadelphia, has been named president-elect of the American College of Physicians. Dr. Sodeman, a cardiologist and authority on tropical medicine, is executive director of the Commission on Foreign Medical Graduates.

The Milton S. Hershey Medical Center reports that **Graham Jeffries, M.D.,** chairman of medicine, and **David Nahrwold, M.D.,** associate professor of surgery, spoke on gastrointestinal surgery at the Central Pennsylvania chapter meeting of the American College of Surgeons at Hershey. **John A. Waldhausen, M.D.,** chairman of surgery, **Malcolm McGavran, M.D.,** professor of pathology, **C. Wayne Bardin, M.D.,** associate professor of medicine, **William Pierce, M.D.** and **G. Frank Tyers, M.D.,** assistant professors of surgery, participated in a panel discussion on "Carcinoma of the Breast."

Maurie D. Pressman, M.D., right, acting director of the division of psychiatry at Albert Einstein Medical Center greets Albert J. Solnit, M.D., left, director of Yale University's Child Study Center and Sterling Professor of pediatrics and child psychiatry at Yale's School of Medicine, on the occasion of Dr. Solnit's address in Philadelphia recently.

Morris Ovitz, M.D., Bradford, has accepted appointment as the medical director of a proposed four-county community mental health center. Dr. Ovitz will be responsible for the coordination of psychiatric clinical services for Elk, McKean, Cameron and Potter counties.

Another honor has been announced for **Eugene P. Pendergrass, M.D.,** emeritus professor of radiology at the Hospital of the University of Pennsylvania. He has been chosen by the American Academy of Achievement as one of fifty giants of accomplishment from the great fields of endeavor to receive the Golden Plate award during the tenth annual salute to excellence weekend, June 24-26, at Philadelphia.

MILTON HELPERN, M.D., (second from left) New York City's chief medical examiner, discussed "Official Investigation of Sudden, Suspicious, and Violent Death" at the Albert Einstein Medical Center recently. Pathologists are, left to right, Bertram Zimmerman, acting general director of Einstein's Northern Division, Warren A. Katz, M.D., program chairman for Ex-Residents' Day (the occasion for the meeting), and Henry Brody, M.D., chairman of the division of laboratories at the medical center.

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new members

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James W. Simpson, M.D., Chit Chat Farms, P.O. Box 275, Wernersville 19565.

BUCKS COUNTY:
Bradford Green, M.D., Royal Oak, Md. 21662.
Dennis R. Gillen, M.D., 4581 Kings Hwy, Brooklyn, N.Y. 11234.
Kenneth L. Wagner, M.D., 1517 Durham Rd., Penndel 19047.

CAMBRIA COUNTY:
Robert F. Berish, M.D., Conemaugh Valley Memorial Hospital, Johnstown 15905.

CENTRE COUNTY:
Robert S. Kish, M.D., 211 W. Beaver Ave., State College 16801.

CHESTER COUNTY:
Robert A. Insalata, M.D., 3615 Lincoln Highway, Thorndale 19372.

CLARION COUNTY:
Sandra M. Clark, M.D., 130 Pickering St., Brookville 15825.
Lawrence M. Clark, M.D., 130 Pickering St., Brookville 15825.

CRAWFORD COUNTY:
Saip E. Turker, M.D., 505 Poplar St., Meadville, 16335.
Hasan K. Tezel, M.D., Bolfview Manor Essex House 8822, Meadville 16335.

CUMBERLAND COUNTY:
Robert J. Virostek, M.D., 804 Belvedere St., Carlisle 17013.

LACKAWANNA COUNTY:
Robert C. Murphy, Jr., M.D., 501 Connell Building, Scranton 18503.
Vernon W. Morgan, Jr., M.D., Turino A-3, Bellefonte Apts., Danny Dr., Scranton 18505.

LANCASTER COUNTY:
Carl G. Johnson, M.D., Eden View Rd., Masonic Homes, Elizabethtown 17022.
John J. Corcoran, M.D., 8 W. Roseville Rd., Lancaster 17601.
Dominador G. Ignacio, M.D., 259 N. Sixth St., Columbia 17512.
Dale W. Boyd, M.D., 822 Marietta Ave., Lancaster 17603.
Leigh W. Kendall, M.D., 948 Olde Hickory Rd., Lancaster 17601.

LEHIGH COUNTY:
Javad Sholehvar, M.D., 1556 Olympic Circle, Whitehall 18052.
Jeffery E. Burtaine, M.D., 554 Benner Rd., Allentown 18104.

LUZERNE COUNTY:
Henry B. Friedman, M.D., 610 Wyoming Ave., Kingston 18704.

MERCER COUNTY:
Morris Ovitz, M.D., 133-135 N. Bennett St., Bradford 16701.

MONROE COUNTY:
William L. Jeffrey, M.D., General Hospital of Monroe County, East Stroudsburg 18301.
Barbara C. Wagner, M.D., 46 S. Green St., East Stroudsburg 18301.

MONTGOMERY COUNTY:
Gordon S. Clement, M.D., Gravers Rd., R.D. 4, Norristown 19401.
Carol P. Webber, M.D., 1538 Dekalb St., Norristown 19401.
James T. Gourzis, M.D., McNeil Labs., Ft. Washington 19034.
Lina C. Gutierrez, M.D., 1758 Sterigere St., Norristown 19402.
Sarah B. Nelson, M.D., 898 Crestline Dr., Blue Bell 19422.
Paul R. McIlhenny, M. D., 1 Maple Ave., Hatboro 19040.

MONTOUR COUNTY:
Joseph A. Weader, M.D., Geisinger Medical Center, Danville 17821.
William M. Sanders, M.D., Geisinger Medical Center, Danville 17821.

NORTHAMPTON COUNTY:
Maria L. Panayotova, M.D., 65 E. Elizabeth Ave., Bethlehem 18018.

PHILADELPHIA COUNTY:
A. Charles Winkelman, M.D., 1700 Butler Pike, Conshohocken 19428.
M.B. Wingate, M.D., 620 Cambridge Rd., Bala Cynwyd 19004.
Misao Takeda, M.D., 1209 W. Wynnewood Rd., Wynnewood 19096.
Herbert S. Rigberg, M.D., 825 Westminster Rd., Elkins Park 19117.
Herman I. Libshitz, M.D., Hopkinson House, Apt. 1111, Philadelphia 19106.
Crawford D. Park, M.D., 4424 Pine St., Philadelphia 19104.
Herbert Notkin, M.D., Apt. C-222, Cedarbrook Hill Apts., Wyncote 19095.
Audrey E. Evans, M.D., 226 W. Rittenhouse Square, Philadelphia 19103.
June E. Greenspan, M.D., Hahnemann Medical College, 314 N. Broad St., Philadelphia 19102.
Juan R. Guerrero, M.D., 3901 Conshohocken Ave., No. 81, Philadelphia 19131.
Alan D. Watson, M.D., 322 Delancey St., Philadelphia 19106.
Denetrios G. Kimbiris, M.D., 230 N. Broad St., Philadelphia 19102.
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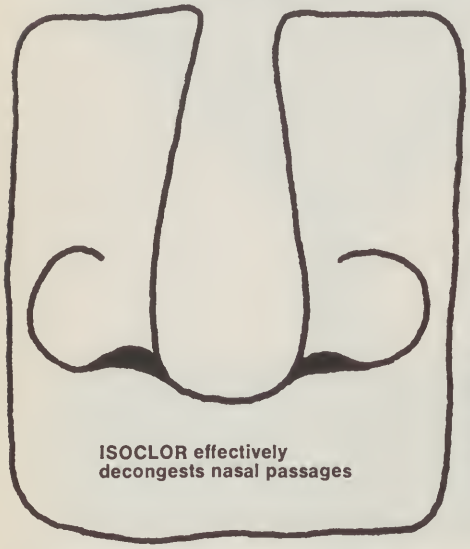

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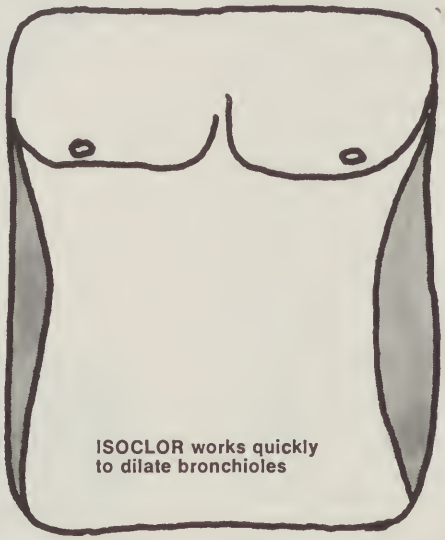

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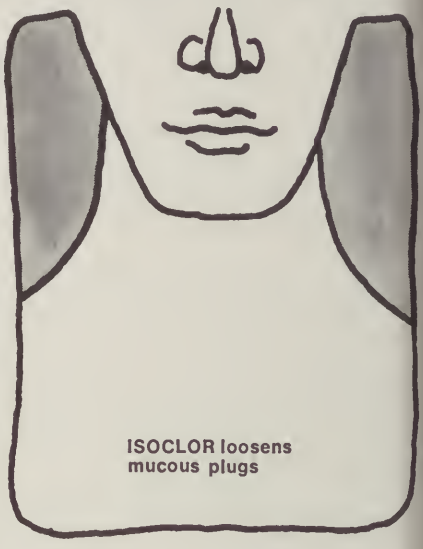
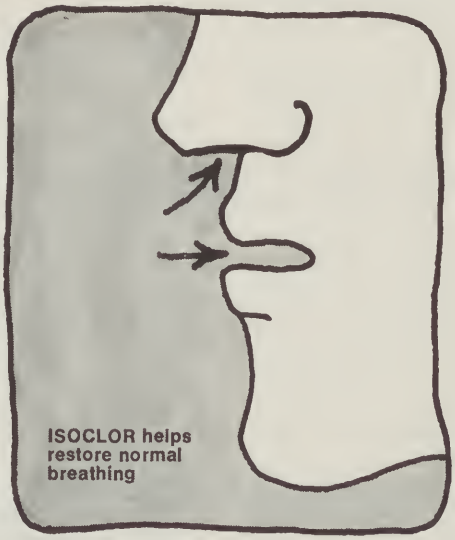


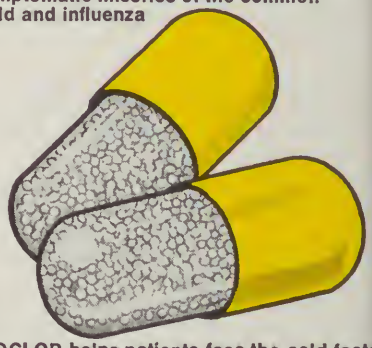
ISOCLOR loosens mucous plugs

ISOCLOR relieves runny eyes



ISOCLOR helps restore normal breathing

ISOCLOR promptly and effectively combats symptomatic miseries of the common cold and influenza



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COMPOSITION: Each tablet or 2 teaspoonfuls of liquid contains:
Chlorpheniramine Maleate.....4 mg.
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30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
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'Let George say it'

Feelings of guilt

GEORGE A. ROWLAND, M.D.
Millville

When our country decided to hold the Nuremberg trials and prosecuted General Yamamoto of Japan, it became inevitable that charges would some day have to be brought against U.S. soldiers for the same kind of misbehavior.

Almost for the first time in history, the victors in World War II presented their case with the stated assumption that they would as readily have charged their own leaders with similar crimes if there was a case against them. Whether this was entirely true is certainly open to question, but the subject was aired and it has affected the conscience of the American people.

Since the earliest times it has been accepted procedure to punish the losers of wars for their infamous conduct. Usually it has been unofficially recognized that the real crime was in losing, and only to the victors belong the spoils. Just over a century ago the propriety of soldiering as a career had never been questioned. The military was considered the highest profession open to a young man. Very conveniently people closed their eyes to the brutal facts of conflict. Florence Nightingale in the Crimea and Clara Barton in the American Civil War were among the first to bring the bloody truth to public view.

Conscientious objection first became a problem in World War I. Most people felt then that the position was one of cowardice rather than idealism. The cleansing fire of war was still a tenet of belief.

Today nobody believes that war is good in itself.

The My Lai trials have been terribly disturbing to the American conscience. The guilty verdict does not reflect only upon higher officers. In the last analysis, it reverberates against every American. Since we are the people who pay for the war, and by our silence permit it to continue, some of the responsibility for the crime, if it is one, must be borne on our shoulders. It is no wonder that this has caused such turmoil.

Not far removed is the question of responsibility for aerial bombing. This anonymous procedure that has resulted in the maiming and slaughtering of countless thousands of non-combatants is carried out by our most heroic warriors. How can we count their murders as different from My Lai?

For present day men, war is inseparable from guilt. As a nation our psyche is on the horns of a dilemma. On the one side is the duty of the strong to combat the forces of evil, on the other the frightful toll extorted from the innocent victims of war. If we must bear this burden of guilt, then we will have to clean up all wars or give up the luxury once and for all.

PAC packs a punch

"Does it pay to back candidates?" "How much effect does medical political action really have?" These are legitimate questions raised by physicians. The answer is a resounding yes to the first question, according to Wesley W. Hall, M.D., president-elect of AMA. He said in a recent conference in Las Vegas, in answer to the second query, that medical political action packs almost as much punch as the two major political parties and labor's committee on political education.

In 1970, 185 candidates were backed by the American Medical Political Action Committee, and 140 of them won their races.

In Pennsylvania, PaMPAC supported 94 candidates. Of that number, 80 were elected, and many in the legislative halls have been appointed to committees handling the legislation concerning health care and medical affairs.

It pays off to support candidates. Medical political action is effective.

To the editor:

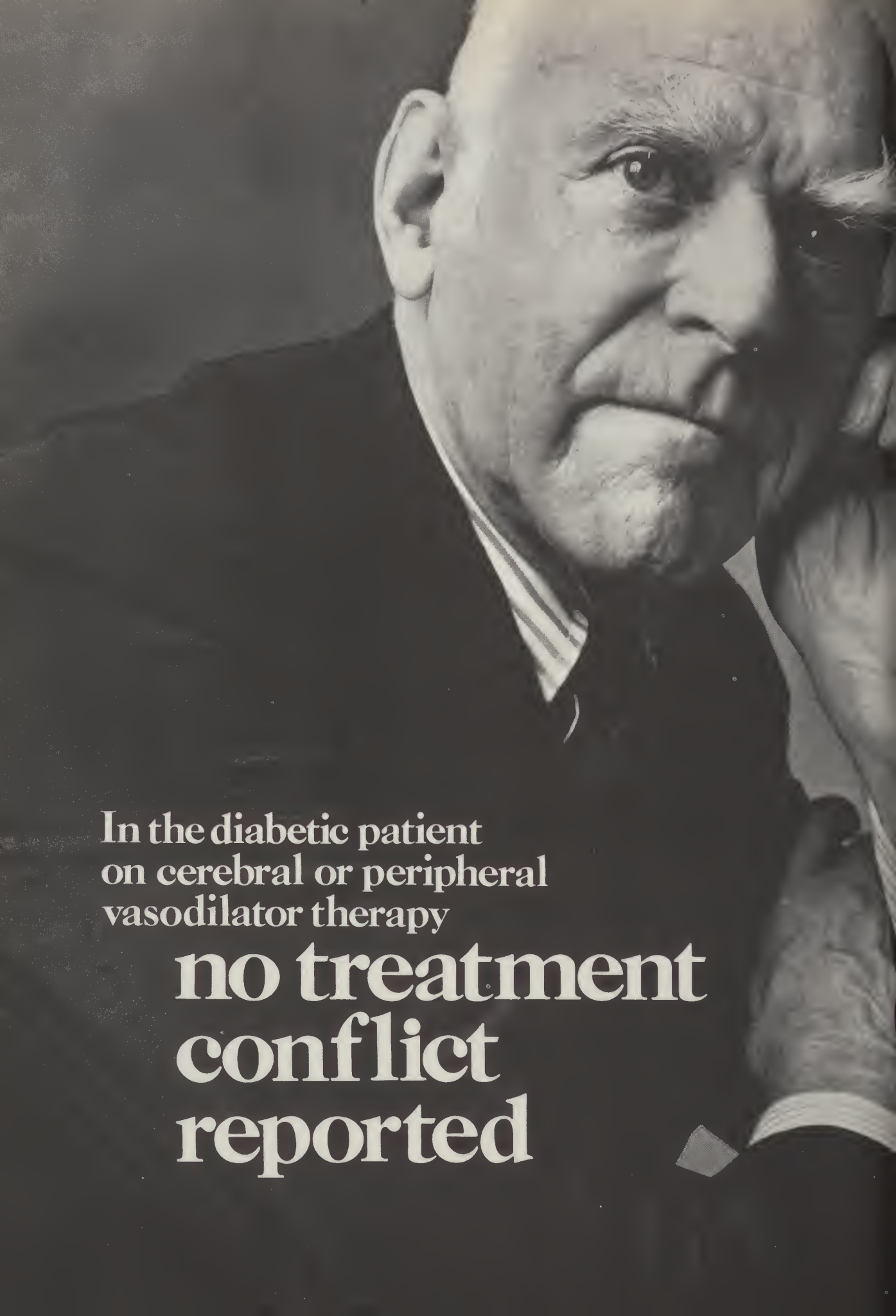
I have just finished reading your article in the April 1971 issue of PENNSYLVANIA MEDICINE entitled "Physician Shortage? Here are Answers." I was especially interested in your statement that little has been done about the other health care professions— dentists, podiatrists, etc., to involve these groups in overcoming the shortage of physicians.

Speaking for my profession and my school, we have under construction a new classroom facility which will cost approximately $9,000,000. With the completion in 1972 we will accept an incomg class of 112 students. We have an excellent faculty organized and our curriculum is constantly under review to train our students to participate in comprehensive health care. I would be most anxious to cooperate in any way to fulfill the challenge of your editorial, and to this end I enclose a recently completed Curriculum Study and a copy of our College Bulletin, which may provide additional information relative to podiatry's role in the comprehensive health picture.

Again, my congratulations on a well written editorial.

Sincerely,

James E. Bates, D.P.M., President
Pennsylvania College of Podiatric Medicine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In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[2-5] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[3,5] and observation of clinical improvement.[2,4]

Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODILAN tablets, isoxsuprine HCl 10 mg, and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories.

References: (1) Samuels, S. S., and Shaftel, H. E.: J. Indiana Med. Ass. *54*:1021-1023 (July) 1961. (2) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. (3) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (4) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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PENNSYLVANIA MEDICINE

Emergency Medical and Health Services in Pennsylvania

Present Status
Recommendations for Improvement

The first section of this White Paper represents a summary of the data which the Commission on Emergency Medical Services was able to collect, much of it piecemeal. The second section on recommendations is the result of countless hours of work by the Commission. The common thread which binds these two sections together is the day-to-day realization of all the commission members of the many obstacles to the delivery of good emergency medical care.

The recommendations may, indeed, seem too harsh or too impractical; but the author's only apology is the delay in bringing this document to the attention of responsible persons within the Commonwealth.

Those who are not in agreement with our recommendations should feel free to contact the commission, but those who may disagree with our sense of urgency need only assess the system of delivery of emergency medical care in his local area to become a convert.

The Pennsylvania Medical Society
1970 Commission on Emergency Medical Services

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Requests for reprints of this paper, comments or criticisms, may be sent to William F. Bouzarth, M.D., Chairman, PMS Commission on Emergency Medical Services, Episcopal Hospital, Philadelphia 19125.

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Preface

Increasing demands for emergency medical services throughout the country, coupled with a growing awareness of their deficiencies, necessitate a re-evaluation and re-orientation of existing programs.

Services related to emergency care may be considered in three phases: (1) those rendered prior to injury or illness (planning); (2) those involving treatment at the scene of the emergency and during transportation to the hospital; and (3) those provided within the hospital.

National surveys have indicated deficiencies in all three phases, particularly in the "extra" hospital emergency health services. Specifically, training programs for emergency medical technicians on ambulances and the certification or licensing of ambulance services are limited. These problems are currently under study by the National Academy of Sciences-National Research Council (NAS-NRC), American Medical Association, American College of Surgeons, American Society of Anesthesiologists, American Heart Association, American Hospital Association, American Ambulance Association, and the U.S. Public Health Services. "Accidental Death and Disability: The Neglected Disease of Modern Society," a report published by the NAS-NRC, provoked the nation to reassessment and improvement.

In 1969 the Pennsylvania Medical Society established a Commission on Emergency Medical Services. The objectives of this commission are fourfold: (1) to create an environment for the improvement and modernization of emergency medical and health services in Pennsylvania; (2) to inventory existing emergency medical and health programs and facilities; (3) to develop an outline of programs for improvement; and (4) to develop prototype emergency programs for state, county, and local communities providing a mechanism for assessment of current programs.

To implement these objectives, the commission has developed this report which is designed to identify the status of emergency medical services in Pennsylvania and to recommend programs necessary for their improvement.

This report should be of concern to all responsible authorities throughout the state. It is necessary to establish priorities in order to bring emergency medical services quickly to a more effective level. Although this report has been developed by the health professions, the changes necessary for improvement will require public involvement, legislative support, and a broader coordination of medical, ambulance, and communication services at both voluntary and governmental levels.

Introduction

Emergency medical services should provide a system which will respond so effectively that the maximal number of lives will be saved, and the disability from acute illness and injury will be reduced to a minimum.

Traditionally, the focus of these services has been the hospital. It is increasingly recognized, however, that the hospital medical staff alone cannot be responsible for life and death. Many organizations and individuals are concerned, including the general public, its governmental agencies (e.g., the police, fire and health departments), ambulance services, the insurance and communications industries, safety organizations, news media and other individuals and organizations involved with community health.

Historically, Pennsylvania has given limited attention to emergency planning. In 1951 a Pennsylvania Council of Civil Defense was established by law. Beginning in 1965, it assumed the supervision of 165 packaged disaster hospitals assigned by the federal government. It has become obvious, however, that disaster planning is too limited to serve the emergency care needs of the Commonwealth or the Nation.

The Pennsylvania Department of Health, in 1964, published an "Ambulance Attendant Training Manual" and initiated a training series which has provided some basic instruction for almost 15,000 individuals. In 1970 at the urging of the Pennsylvania Medical Society, the Pennsylvania Department of Health established a task force on emergency health services within the Advisory Council on Comprehensive Health Planning.

The Committee on Emergency Medical Services of the NAS-NRC and the American College of Surgeons recommended new standards in the design and equipment of ambulances, the training of ambulance attendants, and the emergency services to be rendered. [17,18,29]

While all states have been informed of the need to take action regarding traffic injuries, more broadly based action was not initiated until the National Highway Safety Act of 1966 directed that emergency medical services should be an integral part of all federally assisted highway programs. This led to federal funding for communications, equipment, and training programs for the states. By the Spring of 1970, thirty-five related projects had been supported by the National Highway Safety Bureau throughout the state. One of the most notable private programs in the state has been "Freedom House: Ambulance Service of Pittsburgh."[30] This group has been responsible for much of the original thinking regarding emergency services in the nation, particularly the role of professionalism in emergency ambulance services.

While there are isolated examples of what might be achieved* by following the recommendations of the NAS-NRC,[17,18] such services are available to only a small segment of the population. Little coordination exists between Pennsylvania's approximately 1,000 ambulance services and its 259 hospital emergency rooms. There is little professional direction of ambulance services and it is almost impossible to assess ambulance service effectiveness with present data. National data makes it obvious that many victims of heart attacks can be saved by proper life-support care, but this requires an integrated, highly professional response. Pennsylvania as a whole is not capable of such a response.

In order to meet the responsibilities of the health professions in the field of emergency care, the Commission on Emergency Medical Services has defined the following goals:

1. A system for the delivery of high quality emergency medical care should be developed for all of the people of Pennsylvania. Citizens ought to be educated as to where they can obtain such care twenty-four hours a day, seven days a week.

2. The various health professions involved in providing emergency medical care should be organized in community councils for planning and coordination of services.

3. Ambulance services should be highly professional. Ambulance attendants (emergency medical technicians) should be trained, licensed, and equipped to render all essential life support at the scene of the emergency and during transit to the hospital.

4. Specialized hospital units, such as burn units, coronary care units, head injury units, and acute psychiatric units should be available on a regional basis. The public as well as the health professions ought to know of their availability.

5. A state-wide system of communications should be developed to permit any person (patient or professional health worker) to seek immediate advice relative to emergency medical care. All ambulances and hospital emergency departments should have the capability of two-way voice communications. As a result, hospitals could more effectively prepare to receive the individual patient and overcrowding would be minimized by controlled distribution of multiple casualties to various hospitals.

6. The natural history of the "emergency diseases" and their predisposing factors should be documented so that both prevention of emergencies and future planning would be possible.

7. The quality of emergency care should be continuously reassessed.

8. The public should be taught the fundamentals of first aid.

9. Liability in the case of injuries should be determined on the basis of impartial, expert testimony.

* *Citizens Ambulance Service of Indiana. Freedom House of Pittsburgh, and Mutual Aid of Greensburg.*

Pennsylvania:

the people and their emergency problems

As the third largest state, Pennsylvania's population in 1970 was 11,793,909. The two largest cities are Philadelphia and Pittsburgh with 1,948,609 residing in the former and 520,117 in the latter. Rural areas are as sparsely populated as almost any in the country. Only 4,926 citizens live in Forest County, the smallest of the sixty-seven (1970).

Slightly over one-half of the total population is under the age of 35 years. This is a group in which trauma is currently the major cause of death. Approximately ten percent of the population are under five years of age. Those over 60 years of age in the state are estimated at 1,665,300 (1964).

The national death rate from heart disease is 365 per 100,000 population each year. Among the total of 130,802 Pennsylvania deaths occurring in 1968, 54,402 died from heart disease, an incidence of 470 per 100,000. Accidents across the nation result in 57 deaths per 100,000. In Pennsylvania, in 1968, the accidental death rate was 47 per 100,000— the motor vehicle being the primary offender, followed by home and occupational injuries. Among the 50 states, Pennsylvania ranks ninth in accidental death rates.

Based upon the national incidence in 1965 (52,000,000 accidental injuries resulting in 100,000 deaths), Pennsylvania would expect 2.5 million injuries as well as a recorded 5,589 accidental deaths (1968). Calculated on the indices, there would be annually approximately 500,000 partially disabled and 19,200 permanently disabled among Pennsylvania citizens. The national cost in lost wages, hospital and medical expenses, in benefits paid to the injured, and property damage from accidents now exceeds $22.6 billion annually. This might be calculated to cost Pennsylvanians each year in excess of one billion dollars.

Traffic Accidents, Injuries, and Fatalities

In the United States, annual traffic deaths now exceed 57,000 annually. This represents essentially one-half of all deaths from accidental injuries. This national death toll on the highways has been increasing at the rate of 3 to 4 percent annually, an annual increment of almost 2,000 deaths.

The highways in Pennsylvania became a state responsibility when one of the first state highway departments was established in 1903. There are now more than 44,000 miles in the state system, the largest major segment being the addition in the past 10 years of 1,585 miles of interstate highways. The total mileage in municipal and other non-state roads is unknown.

Coincident with this increase in high speed road surfaces has been the rise in highway accidents. In 1968 (the latest Pennsylvania traffic accidents statistical summary available) there was a total of 279,663 vehicular accidents reported, involving 2,410 fatalities. The largest number of deaths occurred in the age group 45-64; the second largest in the group 20-24; and the third largest in the group over 64.

In terms of traffic injuries, there were 138,389 injured in 1968, the age of only one-half of the victims being recorded. Almost 39,000 of those recorded were under the age of 24 with the largest group being 15 and 19 years (15,394).

During 1968, there were 104 deaths on the Pennsylvania Turnpike, a death rate of 3.6 per 100,000,000 vehicular miles. The national turnpike average was 2.7 deaths per 100,000,000 miles. On rural roads, the national death rate was 7.5 or twice that of the Pennsylvania Turnpike.

On Pennsylvania's highways, almost 66,000 of the 279,663 accidents occurred between the hours of 3 and 6 p.m. The incidence was highest on Friday, Saturday, and Sunday. In 1968, the worst month for injuries was December, but deaths occurred more frequently in August.

A four-year study in Philadelphia indicated that in approximately three-fourths of fatal traffic accidents, death

occurred before the victim reached hospital care. The majority of deaths was due to head injuries and/or crush injuries of the chest.

In reviewing the frequency of deaths and injuries in rural versus urban areas, the following 10 counties were considered urban: Allegheny, Chester, Dauphin, Delaware, Erie, Lehigh, Luzerne, Montgomery, Northumberland, and Philadelphia. Two-thirds of traffic deaths occurred in rural counties (1,620 deaths) and 52% of the injuries (72,272); hence, the case mortality rate is higher in rural areas. This is consistent with the national experience in rural and urban areas and points out the special need for improved emergency medical services in these areas.

More than half of traffic deaths and almost three-fourths (67,537) of injuries occurred in good weather. Eighty traffic deaths occurred during snowstorms.

Head-on collisions accounted for only 171 of the traffic deaths and 1,781 of the injuries. The majority of fatal accidents occurred on tangentially curved sections of road or at intersections. An important observation was that 785 of the deaths and 21,000 injuries resulted from the vehicle hitting a "fixed object," pointing out the need for better road design. The automobile itself was by far the major vehicle involved (1,789 deaths and 76,829 injuries). Trucks were involved in 203 deaths and 7,143 injuries. The motorcycle was the primary vehicle in 77 deaths and 1,524 injuries.

While speeding or driving on the wrong side of the road accounted for 1,200 of the total highway deaths, tailgating was the single most common cause of injuries (29,000). Drowsiness accounted for 80 fatalities and 1,820 injuries. Nationally, approximately half of traffic fatalities involve alcohol. The role of drug abuse in accidents is unknown.

Pennsylvania has 12,918 school buses which travel 132,000,000 miles per year; 1,240,473 pupils are carried daily. The state is second only to New York in the number of pupils so transported. The National Safety Council reports that there were 309 Pennsylvania pupils injured in traffic accidents in 1968. Of these, the Bureau of Traffic Safety recorded two deaths and 121 injuries involving school buses.

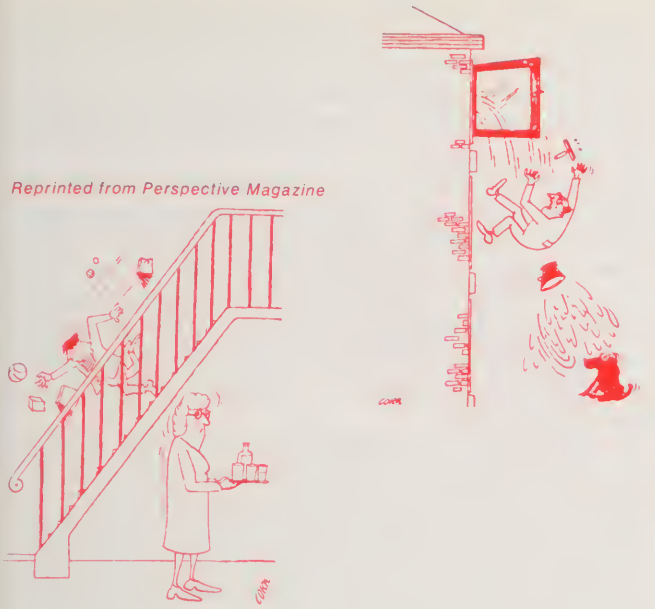
Recently, it was pointed out that at current rates, a male citizen of Philadelphia, if he lives to 65, has a 70% chance of being killed or injured in a traffic accident within his lifetime. At the current rate, he will also wreck an average of approximately 4.4 automobiles in this same span of time.

Death and Injury from Non-Traffic Accidents

Of the 5,598 accidental deaths in Pennsylvania in 1968, 2,899 were unrelated to traffic accidents. The safety record in Pennsylvania industry has steadily improved. The lowest rate of such injuries in the state is recorded for the metal industries. There were 96,512 "on-job" injuries reported to the Bureau of Workmen's Compensation for 1968, however, which represented a 5% increase over 1967. Fatalities were reduced by 40 deaths during the same period, there being 626 in 1968, down from 666 in 1967. This can be compared to 1,405 deaths from injuries in the home or 12 deaths per hundred thousand. Death from farm injuries in Pennsylvania has increased 14% in the last 10 years, while such accidental deaths in industry decreased 25%.

Improvement in deaths from mining accidents in the state reflects, in part, the safety practices developed by this industry. In 1964, there were 42 deaths in both the anthracite and bituminous mines, as compared to 1,000 deaths in 1927.

Pennsylvania has never won a Trustee's Award offered by the National Safety Council for low accident rate, although Bethlehem was recognized in 1966 in the category



of cities under a population of 350,000. Allentown is one of the few in the country reporting its accident rate, which in 1968 was 31 deaths per 100,000 population. It had the fifth highest rate among the 14 reporting cities in the 100,000 to 200,000 population range. Lehigh County reported 41 accidental deaths per 100,000 population. The Bayuk Cigar Company of Philadelphia won the safety award in the tobacco industry for a "no injury record" of 14,314,436 man hours.

Among Pennsylvania residents in 1968, there were 1,190 suicides, 473 homicides, 217 citizens drowned. Fatalities due to fire and flame accounted for 417 deaths. The number of athletic injuries is unknown.

Falls, burns, fires, and suffocation from all causes represent the first four major causes of accidental home deaths. Suffocation among children up to age 4 is a significant cause of home deaths in this age group.

There were 1,900 deaths from accidental poisoning in the United States in 1968, an annual death rate of one per 100,000. This would mean an estimated 116 deaths in Pennsylvania.

Acute Heart Disease: Incidence and Fatalities

In 1968, of the 130,802 deaths in Pennsylvania from all causes, over 49,000 (37%) were caused by coronary artery disease (heart attacks). Available mortality figures from the first six months of 1969 are comparable in all respects.

It has been estimated that 2.8 percent of American adults have recognizable coronary heart disease. In the age group of 30 to 60, one in every ten men and one in every 20 women may be expected to develop a symptomatic coronary heart disease every 10 years.

Approximately half of all heart attack victims die before they reach a hospital. Mortality is highest in the first several hours after the onset of the attack, often because proper resuscitative measures are unavailable. An unknown percentage of stroke victims also die from airway difficulties prior to arriving at the hospital. Other individuals die from congestive heart failure without receiving proper treatment.

While the mortality rate of hospitalized patients with heart attacks has been reduced in recent years by the introduction of specialized coronary care units, virtually no advances have been made toward improving survival of victims before they reach the emergency department. If, as has been estimated, 40% of these individuals with cardiac arrest or fatal arrhythmias might be resuscitated, then 9,800 Pennsylvanians dying each year might survive if sophisticated mobile intensive care vehicles were available. This has been suggested by several pilot programs.

Improvement in survival of heart attack victims will depend primarily on the speed of bringing expert care to the patient.

Pediatric Emergencies and Drug Poisoning

National surveys place accidents as the major cause of death after the first year of life up to age 35 years. Before age 5, deaths in 1968 were due to automobile accidents, burns, drowning, falls, and poisonings, in that order. Drownings become more common in age groups from 5 to 44 years. Accidental poisoning is a common pediatric emergency. Despite educational programs, the overall morbidity and mortality due to accidental poisoning has decreased very little during the last 15 years.

The latest Directory of Poison Control Centers shows 24 units within the state of Pennsylvania. These cities are: Allentown, Chambersburg, Danville, Easton, East Stroudsburg, Erie, Hanover, Harrisburg, Johnstown, Lancaster, Latrobe, Lewistown, Philadelphia, Pittsburgh, Scranton, Sharon, Wilkes-Barre, and York. Although poisoning is not a reportable disease in Pennsylvania, a projected estimate indicates that 40,000 accidental poisonings, resulting in approximately 75 deaths, occur annually in the age group mentioned. Approximately 75% of all the reported poisonings in Pennsylvania during 1968 occurred in children 14 years of age or younger.

The 10 agents that represent the most frequent source of accidental poisoning and compose 80% of the total reported cases are listed in Table 1. Aspirin alone causes approximately one-half of all poisonings in children.

Table I
Accidental Poisonings in Pennsylvania

	Percent of Total
1. Aspirin (all kinds)	58%
2. Vitamins, minerals, hormones	7%
3. Bleaches, deodorizers, disinfectants	6%
4. Soaps, detergents, cleansers	6%
5. Medicine combinations	5%
6. Plants	4%
7. Miscellaneous internal medicine	4%
8. Antihistamines and cold medications	4%
9. Insecticides and rodenticides	3%
10. Turpentine, thinners, and solvents	3%
	100%

The vitamin-mineral-hormone group is the latest addition to the list of ingested drugs. The vitamins potentially toxic to children are A and D. The mineral most frequently ingested is iron, and the most common hormones are thyroid (symptomatic in the majority of cases) and contraceptives (asymptomatic in all cases observed).

Psychiatric Emergencies

Specific statistics relative to psychiatric emergencies are not available. The following assessment is based upon a study of 13 psychiatric emergency centers in Allegheny County during the last quarter of 1968. Of the total 9,005 hospital beds in the county, 505 are psychiatric.

Among emergency room visits in these 13 centers, only 2.3% were directly related to psychiatric emergencies. The majority of these visits was made between 12:00 noon and 8:00 p.m. with the family usually accompanying the patient. Twenty-three percent of the psychiatric patients were brought in by the police; 5% were referred by private physicians. There were no patients in this group under 10 years of age. Thirty-five percent of the patients were considered neurotic; 22% of the diagnoses were related to alcoholism; 14% concerned a suicidal attempt; 5% were drug users; 11% were diagnosed as actual psychotics; and 13% were miscellaneous. Psychosis was more common in the age group of 20-29, which also had the largest group of drug users and suicidal attempts. Alcoholism occurred principally in the age group of 40-60. One-half of the patients seen were admitted to the hospital or were referred to other sections of the hospital. Twenty percent were discharged under their own recognizance.

None of the emergency departments of the hospitals surveyed had a psychiatrist on duty, although one was usually available.

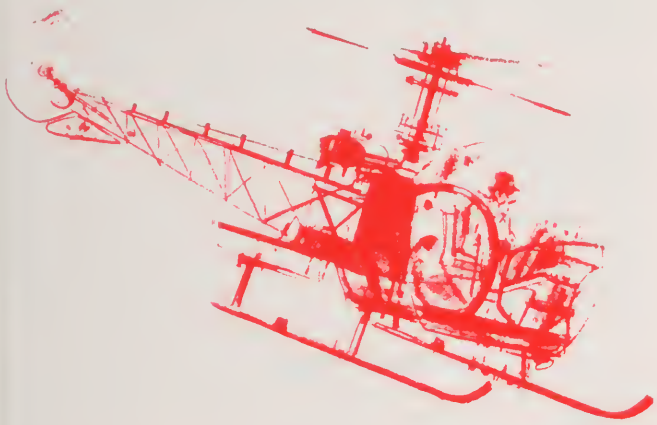
In the last decade, drug abuse has spread throughout the population, making no exception of socio-economic status, sex, or race. The most common drugs are marijuana, barbiturates, amphetamines, LSD, and heroin. Heroin is the most toxic and addictive. The increase in the number of persons abusing drugs apparently holds true for all the above-mentioned drugs. Specific information pertaining to drug abuse (other than the use of heroin within the city of Philadelphia) is not available.

In 1966, in the city of Philadelphia, there were 18 deaths due to heroin abuse; it is projected that over 200 deaths due to heroin abuse will be recorded in 1970. This is as many deaths as were due to automobile accidents in Philadelphia and represents a ten-fold increase in heroin deaths in a four-year period. Over 50 percent of all narcotic-related deaths in Philadelphia recorded from January 1 to June 30, 1970 were recorded in the age group from 15 to 25.

Table II
Narcotic-Related Deaths (January - June, 1970) in Philadelphia

Age	No. Deaths	Percentage
15 years	3	3
16-20	28	31
21-25	21	23
26-30	15	17
31-35	11	12
36-40	5	6
41-45	4	4
Over 45 years	4	4
	91	100%

A review of drug treatment facilities within the city of Philadelphia indicates that these facilities are overloaded to the point of turning people away. Drug addiction has also



spread to the suburbs and rural areas where there are few facilities available for definitive treatment. No studies are available on the extent of the drug problem within the Commonwealth, despite the fact that: (1) this problem may be approaching epidemic proportions and, (2) coma produced by drugs can be successfully treated by physicians trained and equipped for life support.

Emergency Facilities and Services

Ambulances

There has been relatively little concern on the part of the public and the health professions in Pennsylvania about the quality of ambulance services. There are approximately 1,018 known ambulance services, 1,470 ambulance vehicles, and an estimated 21,000 ambulance attendants (mostly part-time volunteers) in the State.

The number of persons and vehicles involved in emergency transportation in Pennsylvania is far greater than in any other state.[20] Examples* suggest that all emergency ambulance needs, excluding elective transfers, for the approximate million urban citizens could be met by approximately 100 full-time attendants staffing 10 vehicles at an annual cost of between one to one-and-a-half million dollars.

There are no records available to indicate the total demand for ambulance services because the law does not require ambulance dispatchers to maintain records. The major cities of Philadelphia and Pittsburgh, with community operated services, report the number of calls to which their ambulances respond but do not always compile data relative to the medical problems involved. The Philadelphia Police Department reported in 1969 that there were 137,249 calls for transportation to a hospital. The Fire Rescue Service in that city answered an additional 20,037 calls for similar emergency transportation. The Pittsburgh Police Department reported 23,091 calls in 1968.

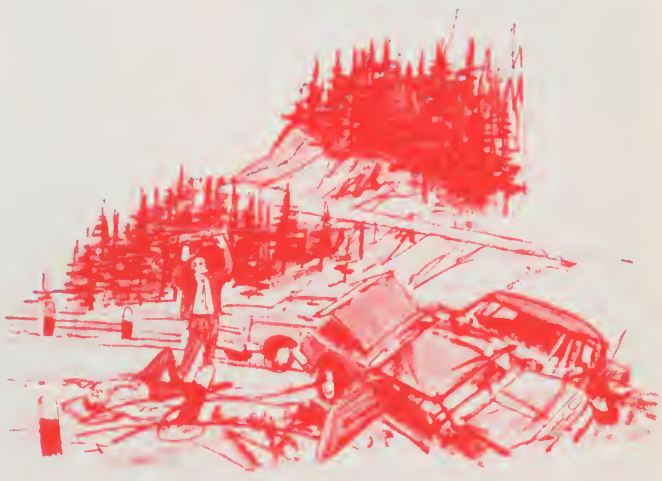
Some interpretation of the demands for these services is possible, utilizing a system of "demand indicators." Based upon a demand ratio of 36.5 calls per 1,000 population, as applied to the 1970 census figure of approximately 11,793,909 Pennsylvanians, it can be calculated that there were almost 430,000 patients transported per year in the Commonwealth. A "rule of thumb" utilized by many ambulance operators suggests that 10,000 people would generate 1.5 trips per day. Utilizing this code, it is estimated that there should annually be approximately 645,502 calls for service in Pennsylvania. A midpoint between the two would be 537,000 calls or approximately 537 requests per ambulance service.

One ambulance system (Citizen Ambulance Service of Indiana, Pennsylvania) has provided (Table III) a 15-month breakdown of 2,159 trips. This service is located in a largely rural county, which supports 6 ambulance services with 9 vehicles. Of the listed trips, 394 were for "lie down transportation"; 205 were for X-ray services only; and 552 were considered emergencies by the telephone dispatcher. Only 388 of the "emergency" trips were subsequently felt to be real emergencies. Among the 378 injured transported, the largest number (126) suffered from injuries of the face and head. The next most common area was the feet and lower extremities (73). Serious multiple injuries numbered 23 or 6% of all injuries. There were 69 DOA's among the 2,159 trips. This ambulance service made 206 trips to hospitals other than the local hospitals, 145 being to the nearest major city (Pittsburgh).

One third of the approximately 1,000 ambulance services in the state are located in the 10 counties considered as urban. In Allegheny County there are 124 ambulance services with 176 ambulances, while there are only 21 services in Philadelphia County with 78 ambulances. Since both counties have about the same population, does Allegheny County have too many vehicles or Philadelphia too few? Utilizing a 30-minute travel distance as a standard, only 6 of the 67 counties in the State are adequately covered.

The "medically underdeveloped" parts of Pennsylvania, roughly corresponding to "Appalachia," cover about 18,197 square miles or 40% of the State's total land area. It has been further pointed out that 5.6% of the state's population is geographically remote, by all standards, from hospital and ambulance services. This 5.6% represents approximately 650,000 citizens.

The providers of ambulance services in the state, grouped



Baltimore, Md., and Jacksonville, Fla.

TABLE III

The following is a breakdown of 2,159 trips made by Citizens' Ambulance Service of Indiana, Pennsylvania, during a period of 15 months from February 1, 1966 to May 1967. It was not until the middle of 1966 that attendants were required to report all first aid treatments. The breakdown of treatments is therefore, not complete.

Type of Trip	
Medical	504
Heart	202
X-ray	205
Stroke	94
DOA	69
Gun Shot	5
Auto Accident	255
Mine or Industrial Accidents	30
Overdose	12
Psychiatric	32
Accidents Other than Auto	135
Obstetrics	9
Case Unknown	45
Courtesy	10
Respiratory	16
Murder or Suicide	3
Fumes	2
Alcoholic	18
Burns	15
Transport	394
Hemorrhage	37
Fight	6
Motorcycle Accident	6
Bicycle Accident	7
Seizure	31
Diabetic	17

Breakdown of Injury Types	
Multiple Injuries	23
Back and Neck	64
Fractured Hip	41
Dislocation	4
Face and Head	126
Chest	17
Hand and Arm	30
Foot and Leg	73

First Aid Treatments	
Oxygen	212
PMR Bag	16
Closed Heart Massage	7
Splints	14
Shock	7
Sling	2

Use of Red Lights and Siren	
Red Lights Both Ways	388
Red Lights One Way Only	164
Siren Both Ways	308
Siren One Way Only	158

according to economic basis of organization, are listed in Table IV and the number of services and vehicles by county are reported in Table V. In 1969 the Pennsylvania Department of Health transferred ambulance activities to the Emergency Health Service Unit of the Office of Comprehensive Health Planning. A new questionnaire and reinventory of the state's ambulance services was undertaken. As of August 1, 1970, 97% of the ambulance services had returned their completed forms. A number of the services listed in 1966 no longer exist, but approximately an equal number of new services had been formed. It is apparent that a depreciation has occurred in the area of funeral director operated services with a compensatory increase in volunteer, city or community operated services.

The National Highway Safety Bureau reported in 1969 that three-fourths of funeral homes providing ambulance services over the nation operated the service at a loss, as did over one-fourth of the commercial ambulance firms. It was pointed out that a number of factors are related to these uneconomic operations: the unpredictable nature of emergency work which provides high fixed annual operating costs (85% to 90% of the total costs of operation); commercial ambulance services expend 60% of their total costs for personnel (versus 80% by municipal services); the annual expense of operating one commercial ambulance service and one vehicle 24 hours a day is estimated between $60,000 and $65,000 (if personnel are paid at minimum wages and receive no overtime); revenue is uncertain and variable; minimal wage and hour legislation on a system of 24 hours on, 24 hours off, results in an average cost per man hour of below $1.60, but produces a weekly wage greater than $100. A distinct advantage of voluntary ambulance services, economically, is that the major component of personnel costs has been appreciably reduced. Unfortunately, volunteer services often lack proficiency.

The Fair Labor Standards Act of 1966 has further raised personnel costs. Approximately one-third of the funeral homes have reported that they will discontinue services when ambulance standards as outlined in the Highway Safety Act are fully implemented. Some volunteer and commercial firms may not be able to continue.

Health insurance companies, such as Blue Cross and Blue Shield, have not had a significant impact on the economics of ambulance services up to the present time. They have, for the most part, not provided for payment of ambulance fees to beneficiaries. There are no uniform rates for ambulance transportation. Schedules for payment of ambulance services by Blue Cross are contained in certain group contracts within industry and in "major medical" plans but not in the plans offered to the general public. In many instances, ambulance operators render service without charge. Others charge a specific rate for all calls, some charging as much as $45 per call. Other rates vary between these limits.

There are no available data regarding the costs of operating governmental emergency ambulance services in the major cities of the state. Pittsburgh, for example, operates 14 dual purpose ambulances and has 121 police officers involved. The cost of these services is such that the safety director and the police commissioner would prefer to transfer this service out of the department.

There are 2,668 political subdivisions in the Common-

wealth (67 counties, 51 cities, 955 boroughs, 1 town, 1,554 townships). None of these governmental elements is required by state law to provide emergency ambulance service to its citizens. A recent review of budgets of 668 political subdivisions showed that only 23 demonstrated funds for ambulance services. The total amount allocated was $13,091.05, with allocations varying from $50 to $1,500 annually. On the other hand, the same communities allocated $110,011,741.50 annually to their volunteer fire companies. In some communities, a certain part of the money allocated to fire departments was used for support of ambulance services; but in many cases where this was true, the support was minimal. The community, for example, might provide housing for its ambulance in the fire house. Even taking into account this kind of relationship between volunteer fire companies and voluntary ambulance services, it still is apparent that much more money was allocated for fire companies than for ambulance services.

Air transportation (fixed and rotary wing aircraft) is available only on a nonorganized basis and at high cost. There is no program whereby helicopters or other aircraft are used primarily for transportation of emergency victims. The Pennsylvania State Police have four helicopters which can be used for this in conjunction with the highway patrol. The pilots have recently received a five-day training course in first aid at the Harrisburg Polyclinic Hospital. Philadelphia has also contracted for helicopter services. Medical support for training and equipment has been primarily by volunteer physicians. Hospital helipads are slowly being developed.

A survey of the costs of helicopter services in 1968 estimated the annual cost for purchase and operation of a single helicopter to range between $100,000 and $300,000. It does not seem realistic to expect an ambulance helicopter service to "break even" financially without supplementary financial support. Meanwhile, the military has proven the value of the helicopter as a special service ambulance.

A few land vehicles are equipped, but not yet staffed, for mobile intensive care and arrhythmia control. Experience is limited and the cost of equipment and operation on a 24-hour basis is high.

The majority of ambulance personnel are inadequately trained, partly because there have been no generally accepted standards for their training.

In 1970 the Pennsylvania Department of Health surveyed by questionnaire the ambulance services of the State. The survey identified 19,465 ambulance attendants. Of this

The Wellsboro Ambulance Association's fully-equipped emergency vehicle is operated by trained drivers under the supervision of the community's fire department. Shown above is a view of the interior from the rear door. Above, left, the driver demonstrates equipment. To the left is a view of some of the additional equipment carried by this ambulance.

TABLE IV

PROVIDERS OF AMBULANCE SERVICE
BY TYPES IN PENNSYLVANIA

	1966*	1970**	
Funeral Home	237	200	
Privately Owned and Operated	36	68	(27%)
Municipal Owned and Operated	39	63	(6%)
Community Nonprofit (Paid Personnel)	11		
Community Sponsored Club-Assoc. Rescue Squad (Volunteer Personnel)	208	673	(66%)
Associated With Volunteer Fire Companies	385		
Hospital Owned and Operated	10	9	(1%)
Other (Airport, Nursing Home, etc.)	3	5	
TOTAL	929	1,018	

* From director of ambulance service in Pennsylvania, November 1966 (Pennsylvania Department of Health)

** From survey of ambulance services in the Commonwealth of Pennsylvania, August 1, 1970, emergency health services unit, office of comprehensive health planning, Pennsylvania Department of Health

group, 14,931 had completed the advanced Red Cross training in first aid and 885 had completed the Bureau of Mines training program. Following completion of one of these courses 4,205 passed the course given by the Pennsylvania Department of Health. When compared to the standards as outlined by the NAS-NRC, the deficiencies in the training experience of these ambulance groups were marked.

Ambulance services have received relatively little attention from local government. Among 52 counties surveyed in Pennsylvania, only 3 indicated that ambulance services were considered important; sewage, garbage and trash disposal, water supply, roads and parking were assigned higher priorities.

Prior to 1960 no state agency in Pennsylvania concerned itself with the training of ambulance attendants. In 1960, with the formation of an Accident Prevention Section of the Pennsylvania Department of Health, activity was directed toward a reduction in the severity of injuries. This led to a survey of police chiefs in Pennsylvania regarding ambulance services in their areas. As a result of deficiencies found in training, a statewide voluntary training program for ambulance attendants was evolved. County medical societies offered their support and a training manual was published by the Pennsylvania Health Department. Subsequent assessment indicates that a large number of attendants remaining on the job are still untrained. In Indiana and Jefferson Counties, it was noted that among the 500 attendants who had been certified between 1965 and 1969, only 20 are presently engaged in ambulance work. Hostility from vested interests to legislated requirements for ambulance training has been noted throughout the State, much of it being reflected in testimony before a Task Force of the State Legislature, which has been holding hearings for the past three years with reference to a model ambulance law for the state (House Bill No. 873). There is no legal requirement for the training of ambulance attendants at the present time. The Commonwealth requires formal training programs and certification of its barbers and morticians. It permits anyone with a driver's license to qualify for emergency care and transport of the acutely ill and injured. Actually, the Commonwealth has no list of individuals rendering ambulance care. In addition to the basic training of ambulance attendants, mechanisms for continuing on-the-job training are not generally available.

Training is currently related to the legal liability of the

ambulance attendants. According to Act of the General Assembly No. 165, dated October 9, 1967, ambulance personnel are exempted from civil liability for damages and injuries to persons to whom they are giving first aid or transportation except when such damages or injuries result from intent, gross negligence, or the liabilities connected with the operation of a motor vehicle. This exemption is valid, however, only when said attendants have certification that they have passed the Red Cross or equivalent training courses in first aid.

If an ambulance service is to provide an opportunity for treatment of the victim, not just transportation, it must be equipped for resuscitation and life support. A report of May 1965 by the Health and Welfare Association of Allegheny County indicated that 22% of all ambulance services in Allegheny County lacked a resuscitator; 27% lacked splints for fractures, and 13% lacked first aid kits. The greatest deficiency was among those ambulances provided by funeral directors, where 31% lacked first aid kits and 54% lacked a resuscitator. A previous survey in 1960 had revealed less than one-half of 54 ambulances carried even the minimum equipment as recommended by the American College of Surgeons. The dual-purpose "ambulance" operated by the Philadelphia Police Department has minimal equipment and no oxygen. In few communities the stretchers and emergency supplies are interchangeable between ambulances and hospitals.

Ambulances need artificial ventilation devices (preferably manually operated), airways, oxygen inhalation equipment (3,000 liters of oxygen in two tanks at 500 psi), suction equipment, a backboard for cardiac compression, as well as immobilization equipment for fractures and wound dressings.

As a result of the Federal Highway Safety Act of 1966, the Pennsylvania Department of Highways produced a document entitled "Pennsylvania Highway Safety Program." This document indicated that there were no standards for two-way voice communications by ambulance services within the state. A policy statement concluded that the development of a "Comprehensive Communications System," including two-way voice communication with a base station and with a hospital emergency room, was recommended. The report further stated that authority will be requested to require the installation of a communications system as indicated in House Bill 873 pending before the Pennsylvania State Assembly.

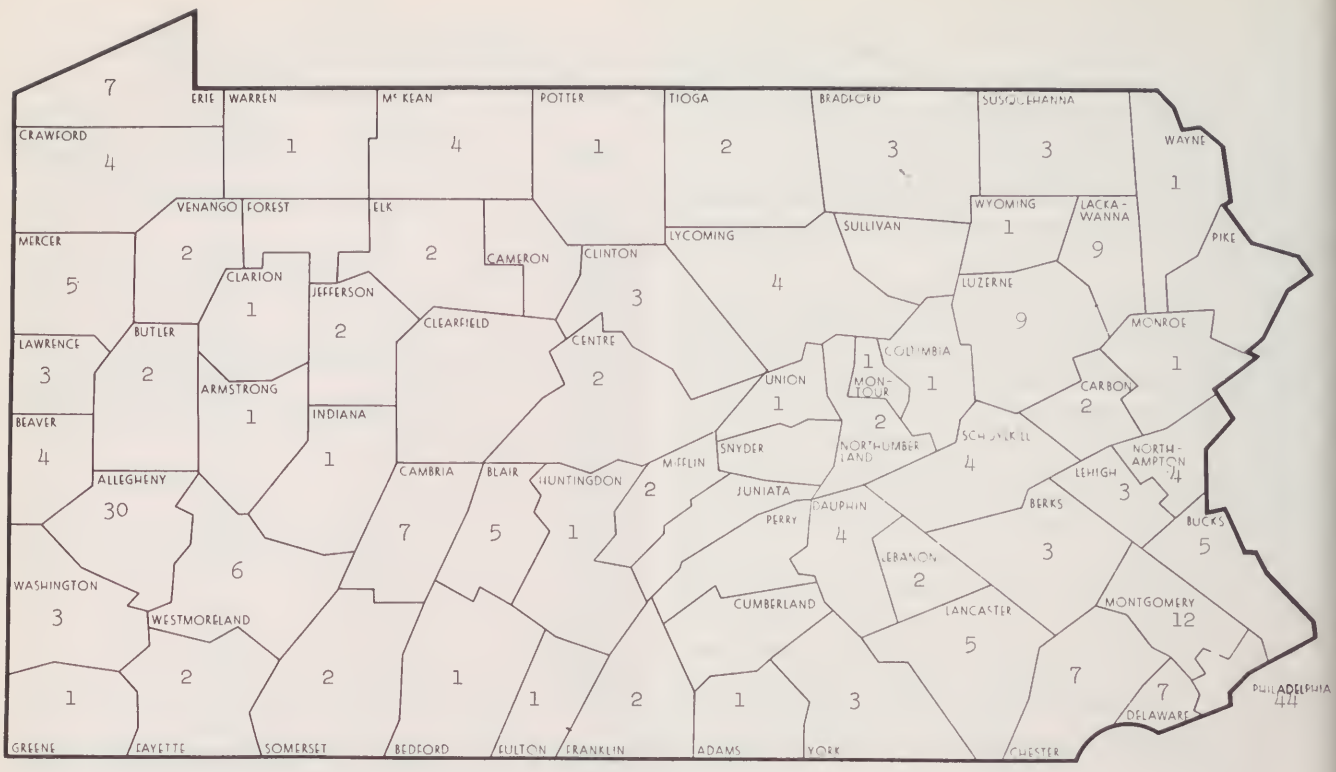
While 65% of the ambulance vehicles in the state have communications with a base station, the 1970 survey by the Pennsylvania Department of Health revealed that only 315 of the 1,018 ambulance services of the state (31%) have the capability of direct two-way radio communication between the ambulance and the nearby hospitals. Using the county as the principal geographic unit and assuming a basic system of a two-frequency (110 volt) unit for each ambulance with digital dialing, the cost of the communications equipment for each ambulance was estimated to be $1,650. A statewide program of this type for 1,000 ambulances, 300 hospital units, 800 base stations and 66 central dispatch control units permitted an estimated cost for a statewide system of $4,531,000. The state highway safety report further estimates that a minimum of five years

TABLE V

AMBULANCE SERVICES BY COUNTY
WITH NUMBER OF VEHICLES (1970)

County	Number of Services	Number of Ambulances	Number of Rescue Vehicles
Adams	9	10	5
Allegheny	124	176	71
Armstrong	8	10	3
Beaver	18	27	4
Bedford	9	12	3
Berks	20	28	4
Blair	10	15	3
Bradford	6	10	1
Bucks	19	37	5
Butler	19	21	1
Cambria	32	40	11
Cameron	2	3	-
Carbon	8	11	4
Centre	12	19	3
Chester	19	25	4
Clarion	14	23	-
Clearfield	12	17	6
Clinton	4	7	5
Columbia	6	8	2
Crawford	8	15	8
Cumberland	16	22	8
Dauphin	19	21	4
Delaware	32	42	17
Elk	6	9	3
Erie	12	17	5
Fayette	30	33	11
Forest	1	1	1
Franklin	9	14	3
Fulton	4	3	-
Greene	8	12	4
Huntingdon	6	9	-
Indiana	6	9	-
Jefferson	11	16	3
Juniata	6	9	-
Lackawanna	26	33	15
Lancaster	30	32	7
Lawrence	10	21	1
Lebanon	9	11	4
Lehigh	18	39	5
Luzerne	45	51	10
Lycoming	10	14	7
McKean	11	13	5
Mercer	18	29	7
Mifflin	5	9	4
Monroe	9	17	-
Montgomery	30	48	12
Montour	1	2	-
Northampton	18	27	8
Perry	7	8	2
Philadelphia	21	78	26
Pike	3	4	1
Potter	9	10	2
Schuylkill	26	31	1
Snyder	3	4	-
Somerset	17	26	8
Sullivan	5	6	5
Susquehanna	7	10	3
Tioga	4	10	1
Union	5	8	3
Venango	6	12	3
Warren	7	9	4
Washington	29	42	7
Wayne	14	18	1
Westmoreland	44	60	24
Wyoming	7	8	-
York	27	29	13
TOTAL	1,018*	1,470	396

* Of this group, 972 services provided 24-hour service.



DEPARTMENT OF COMMERCE

would be required to achieve a 75% compliance "providing sufficient federal grant money becomes available."

While the majority of ambulance services, particularly those that are governmentally operated within the state, have central dispatch communications, their only communication with emergency departments of hospitals is via a telephone from the central dispatch center. The absence of communications between emergency departments and ambulances seriously affects the management of injured or acutely ill citizens. Meanwhile, an excellent communications network has been developed by the civil defense office and is being held on a stand-by basis without day-to-day utilization. The need exists to provide a statewide system of radio communication between services actively engaged in emergency care.

Hospitals and their Emergency Departments

Distribution of Hospitals

As of 1969, there were 335 hospitals offering inpatient care in the Commonwealth of Pennsylvania (Table VI). Most, but not all, general hospitals have an emergency facility for outpatient care; others are discriminatory and will not, for example, accept maternity, pediatric, or multiple-injured patients.

The hospitals throughout the State are clustered in the larger cities and the more densely populated areas. Of the sixty-seven Pennsylvania counties, seven have no hospital; sixteen counties have one hospital each; fourteen have two

COUNTY POPULATIONS

County	Pop. 1960	County	Pop. 1960
Adams	51,906	Lackawanna	234,531
Allegheny	1,628,587	Lancaster	278,359
Armstrong	79,524	Lawrence	112,965
Beaver	206,948	Lebanon	90,853
Bedford	42,451	Lehigh	227,536
Berks	275,414	Luzerne	346,972
Blair	137,270	Lycoming	109,367
Bradford	54,925	McKean	54,517
Bucks	308,567	Mercer	127,519
Butler	114,639	Mifflin	44,348
Cambria	203,283	Monroe	39,567
Cameron	7,586	Montgomery	516,682
Carbon	52,889	Montour	16,730
Centre	78,580	Northampton	201,412
Chester	210,608	Northumberland	104,138
Clarion	37,408	Perry	26,582
Clearfield	81,534	Philadelphia	2,002,512
Clinton	37,619	Pike	9,158
Columbia	53,489	Potter	16,483
Crawford	77,956	Schuylkill	173,027
Cumberland	124,816	Snyder	25,922
Dauphin	220,255	Somerset	77,450
Delaware	553,154	Sullivan	6,251
Elk	37,328	Susquehanna	33,137
Erie	250,682	Tioga	36,614
Fayette	169,340	Union	25,646
Forest	4,485	Venango	65,295
Franklin	88,172	Warren	45,582
Fulton	10,597	Washington	217,271
Greene	39,424	Wayne	28,237
Huntingdon	39,457	Westmoreland	352,629
Indiana	75,366	Wyoming	16,813
Jefferson	46,792	York	238,336
Juniata	15,874		

Total Population	11,319,366
Total Counties	67

each; eight have three; eight have four; and the remaining fourteen have five or more (Figure 1).

Emergency Departments: Patients and Costs

General and short-term hospitals report emergency visits to the Pennsylvania Department of Public Welfare, division of medical services and facilities. Certain local governments, as in Philadelphia, make similar tabulations. The Joint Commission on Hospital Accreditation, the Hospital Association of Pennsylvania, and various regional hospital associations have figures only for their member institutions or those applying for membership. There is no uniform system of reporting by all types of hospitals.

Of 71 hospitals in Pennsylvania with internships, 1,594,534 emergency room visits were reported for the calendar year 1969. In Philadelphia, 32 hospital emergency facilities participate in the city's reimbursement contract program. These facilities reported a total of 632,205 emergency visits for the calendar year 1969. For fiscal 1968, 243 general and short-term institutions reported to the Department of Public Welfare a total of 3,018,508 patient visits to their emergency departments.

Little information is available on the type of patients seen in the emergency departments. The data that is available cannot be projected for the entire state. However, it is estimated that 10% of patients seen in the emergency departments will be admitted to the hospital. In addition, 50% of the bed occupancy of non-governmental hospitals is reported to be patients admitted via the emergency department. Table VII represents a survey of 37 emergency departments in Philadelphia. This survey covered an 8-day period, July 14-21, 1969. The range showed a low of 1,828 visits (10.5% of the total) on Sunday, to a high of 2,402 (14%) for Monday. The 7 a.m. to 3 p.m. and the 3 p.m. to 11 p.m. shifts each handled an average of about 42% of the total cases. An average of 44.5% of the total number of cases seen was deemed to be "non-urgent."

Costs of the operation of the emergency departments have been the subject of frequent assessment. In

TABLE VII

EMERGENCY DEPARTMENT VISITS TO 37 PHILADELPHIA HOSPITALS
RANKED IN DESCENDING ORDER BY NUMBER OF VISITS REPORTED
(Eight Day Period)

Hospital Number	Total Patients	% of Cases Non-Urgent	% Total Admitted to Hospital
1	1,372	67	18
2	1,248	-	5
3	788	31	12.5
4	747	30	8
5	733	60	7
6	731	79	6
7	729	78	8
8	695	45	10
9	633	42	6
10	614	29	8
11	597	55	10
12	577	35	14
13	545	20	10
14	543	44	8
15	527	45	8
16	470	80	5
17	470	46	10
18	446	14	8
19	437	36	8
20	431	33	10
21	429	48	14
22	372	47	12
23	362	46	10
24	335	13	8
25	324	59	10
26	323	57	7.5
27	316	40	10
28	282	97	3
29	255	21	7
30	253	61	13
31	217	42	13
32	146	59	20
33	143	37	6.5
34	122	22	1.5
35	74	24	10
36	39	-	1
37	19	68	5
TOTAL	17,344	44.5%	9.7%

Philadelphia the only figure available is the average cost of a visit to the emergency department or out-patient clinic. The Delaware Valley Hospital Council estimates the true cost per visit to be $15.43. Approximately 40% of this is collected from some source, while 60% is not collected. The total loss is, therefore, $10 per visit and represents a 6 million dollar loss in hospital operations in that area. The state pays $4 per visit for certain visits and the city underwrites emergency department costs in Philadelphia to an extent of $650,000 per year. Blue Cross Co-Pay Preferred Subscription Agreements pay for emergency department care, the deductible principle being involved. Workmen's compensation insurance pays for emergency care of industrial accidents.

Although many hospitals indicate that their emergency departments represent a financial liability, groups of physicians have organized and profitably run selected emergency departments.

Categorization of Hospital Emergency Facilities

While the Joint Commission of Accreditation of Hospitals has developed limited standards for emergency services within hospitals, it does not define *optimal emergency care*. Generally, each hospital adapts its emergency capabilities to the community it serves, utilizing its resources of physicians, supporting staff, equipment and space in accord with generally accepted principles. In recent years, the emergency room concept had been replaced by that of the *emergency department*, the latter implying an intrinsic organization of its staff and facilities.

In the past five years, the concept has evolved that evaluation of emergency medical services requires assessment of the total institutional capability for emergency care. It is now apparent that to meet modern emergency medical services, it is necessary to have not only space, equipment, and personnel in the emergency department, but also a major hospital reserve of physicians, specialists, nursing specialists, and technicians, well equipped operating rooms, blood bank, recovery room, and intensive care unit.

State laws in Pennsylvania do not specifically require that hospitals provide emergency services. By designation, many hospitals limit their health services, such as psychiatric or obstetrical hospitals.

These, and all medical institutions, are morally expected to provide limited emergency medical care when necessary. By regulation of the Pennsylvania Department of Public Welfare (1966), medical services are to be provided by each hospital as determined by its governing board and its medical staff and, in the case of proprietary hospital, its license.

In 1966, the NAS-NRC indicated that at least four categories of emergency medical facilities could be identified. Rearranged and slightly modified, these are as follows:

Category I	Major Emergency Care Center
Category II	General Emergency Care Hospital
Category III	Minimal Emergency Care Facility
Category IV	Resuscitation and Referral Facility

This concept has been further supported by the Federal Highway Safety Act of 1966 which incorporated the concept of categorization of emergency facilities in its recommendations for the emergency medical service section of the act. In 1969, the hospitals in Allegheny County were categorized following a survey under the auspices of the Allegheny County Community Council on Emergency Medical Services, and Philadelphia is conducting a similar survey in 1970. Categorization permits the recognition that certain services are available only at specific hospitals. These services need to be known to the ambulance systems and to the public of the area.

Efforts to upgrade the quality of emergency care must require the thoughtful coordination of existing facilities and only then the creation of new ones. Those responsible for provision of emergency care are often not aware of services provided at nearby facilities. Regional and community planning can be made more responsive if the differentiation of available facilities is "spelled out."

Certain facets of emergency care might preferably be transferred from one hospital to specialized units in another hospital. Many such patterns of transfer exist today in the area of psychiatric care, tuberculosis therapy, or rehabilitation. Although detailed recommendations for categorization have not yet been accepted nationally, the following principles are being utilized:

Category I - Major Emergency Care Center: This facility represents a medical center with staff and facilities to render optimal emergency care on a broad basis. Such centers should be organized to receive complex emergency problems requiring the full resources of diagnostic and therapeutic services. A surgeon, internist, and anesthesiologist should be in the hospital at all times.

Category II - General Emergency Care Hospital: Such hospitals should have the capability to provide optimal care for most, but not all, emergency victims. Included should be

TABLE VI

TYPES OF HOSPITALS
IN THE STATE OF PENNSYLVANIA

General Medical-Surgical*	236
General Medical-Surgical, Osteopathic	20
Subtotal, General Hospitals	256
Specialty Hospitals	79
Children's or Maternity	8
Eye or EENT	2
Psychiatric	32
Tuberculosis	8
Institutional Infirmary	8
Convalescent or Rehabilitation	6
Mentally Retarded or Crippled	7
Other	8
TOTAL	335

* Includes 7 VA, 2 Army, and 1 Naval Hospital

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Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, active organic disease of the central nervous system and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . 250 mg.
Vaginal inserts . . 500 mg.

*References available on request.

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most first class community hospitals. A physician plus someone capable of endotracheal intubation should be in the hospital at all times.

Category III - Minimal Emergency Care Facility: This hospital should have essentially the same capabilities for resuscitation and short-term maintenance of life support as in Category II. It should have the capability to provide definitive care of some emergencies and the capability to provide resuscitation and transfer of others. Many hospitals with small staffs should fit into this pattern. Physicians should be on call within 15 minutes and a person capable of endotracheal intubation should be in the hospital at all times.

Category IV - Resuscitation and Referral Facility: This facility may be hospital or non-hospital based, but is equipped for resuscitation in most life-threatening problems. The facility depends heavily on the availability of well-trained allied health personnel who can identify life-threatening problems, communicate rapidly with a physician, initiate life support, and transport the patient to a Category I or II hospital for definitive care.

Liaison Between Ambulance Services and Hospital Emergency Departments

Following World War II, most hospitals discontinued ambulance services. Physicians ceased to staff ambulances and most ambulance services were transferred to other agencies. Expense was a major reason for these changes. However, a number still exist and reconsideration of the system is now taking place across the nation. Questions remain as to whether physicians should be required to ride in ambulances. The question hinges to a certain extent on the problem of differentiating between "true" emergency cases which require quick use of equipment and expertise and cases which really require only "lie-down" transportation to a medical facility.

There are several advantages to such a hospital-based system. There may be quicker response and better communications between hospital personnel and the emergency medical technicians on the ambulance. The teaching atmosphere in the hospital would contribute to the continued education of the ambulance attendant. Closer relations with physicians and nurses insure the ambulance attendant's being a part of the "team". The technician attendant could be continuously involved in patient treatment before and after arrival at the hospital. Follow-up conferences between hospital and ambulance personnel would be more meaningful although few such conferences exist.

The ambulance record provided by the emergency technician would be more important if it could be incorporated into the hospital record. Ambulance services would become a part of the hospital operation. Television, telemetry, and other mechanisms of communications from the ambulance staff could conceivably ungrade their capabilities.

Community Councils on and Statewide Coordination of Emergency Medical Services

In 1966 the National Research Council's Committee on Emergency Medical Services recommended the organization of Community Councils on Emergency Medical Services to provide a mechanism for coordinating those private, governmental, and other health agencies within the community which directly affect emergency medical services. The resources of the American Red Cross, safety organizations, the insurance industry, Committees on Trauma of the American College of Surgeons, medical societies, the ambulance services, health departments, hospital organizations, and others were considered important in the development of a community council. The American Medical Association, through its Commission on Emergency Medical Services, endorsed this concept and published a document, "Developing Emergency Medical Services: Guidelines for Community Councils" in 1970. Nevertheless, little has been produced in Pennsylvania and the true consumer has practically no input.

At the present time, at least four emergency medical councils are organized and functioning in Pennsylvania as follows: (1) the Pennsylvania Medical Society's Commission on Emergency Medical Services; (2) the Allegheny County Council on Emergency Medical and Health Services; (3) the Philadelphia County Medical Society's Committee on Emergency Care; and (4) the Delaware Valley Council's Committee on Emergency Medical Services. In addition, the Crawford, Blair, and Centre County Medical Societies have initiated such efforts as have Indiana County, Venango County, Altoona, Henry Clay Township, Monessen, and Lancaster. None of these latter councils is known to be functioning at this time.

The Commission on Emergency Medical Services of the Pennsylvania Medical Society, appointed in 1968, is responsible to the Society's Council on Education and Science and to the Society's Board of Trustees. Consultants from allied fields serve on the Commission. On March 19, 1969, the commission recommended to the Board of Trustees and Councilors of the Pennsylvania Medical Society the following statement which was approved.

"The Council on Education and Science requests that the policy statement of Emergency Medical Services in the Commonwealth of Pennsylvania be adopted and a letter be forwarded to the governor of Pennsylvania requesting that a council on emergency medical and health services for the

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Commonwealth be established and that the following policy be made available to such Councils for background information and guidance...

"It is generally recognized that a need to improve emergency medical and health services currently exists. This responsibility is a joint effort of the Pennsylvania and component medical societies, health professions, and the governments within the state. Specific goals and mechanisms for implementation have been identified."

This recommendation was forwarded to Governor Shafer by the President of the Pennsylvania Medical Society on March 31, 1969. The governor did not reply. Instead of organizing a Council as a broadly based state-wide group of experts including the Pennsylvania Secretary for Transportation (who is the governor's representative for the development of highway safety and related emergency medical programs), the secretary of health was empowered to develop an advisory committee for planning of emergency medical services as a division of its Bureau of Comprehensive Health Planning. Such a planning group within the Pennsylvania Department of Health has been organized as a task force. This group held its first meeting on June 11, 1970, and has been active since then. Several members serve on both this task force and on the Pennsylvania Medical Society's commission.

Beginning as a committee of the Allegheny County Medical Society in May, 1967, the Allegheny County Council on Emergency Medical and Health Services was chartered as a non-profit corporation in November, 1968.

The Philadelphia County Medical Society created an Emergency Medical Services Committee in November, 1969, as one of its standing committees. This committee, with over fifty organizations represented, has as one of its major charges the improvement of care for *all* within Philadelphia regardless of the patient's station in life.

The Delaware Valley Council, providing a function similar to a Chamber of Commerce in Southeastern Pennsylvania, created an Emergency Medical Service Committee to function as a regional council. There is some overlap of purpose since the Philadelphia County Medical Society had developed a disaster program for the five county area (PREMDOP) a few years earlier.

The full spectrum of requirements for an effective emergency medical system requires regional organization. Communications involving police and fire services must necessarily extend through a "region" of boroughs or counties. No state-wide mechanism currently exists for coordination of such services.

Research in Emergency Medical Services, Trauma, and Acute Illness

It was apparent, prior to a recent survey, that research in emergency medical care in Pennsylvania is negligible as compared to the efforts and money expanded in the study of cancer, chronic heart disease, and similar problems of chronic disease. Investigation in the area of emergency care is undoubtedly carried out on a small scale throughout the Commonwealth. Most projects, however, are the result of efforts by medical schools and health departments.

The dean of each of the seven Pennsylvania schools of medicine was asked to survey the research and development programs in early 1970 as to the specific programs funded for research in emergency medical care, trauma, and acute illness. In four schools, no such research efforts could be identified. In a fifth school, approximately $100,000 a year was being spent on studies specifically relating to the hemodynamic and physiologic changes associated with trauma. At this school, an equal amount was spent in refining the treatment of the patient with acute coronary artery illness. Another medical school is engaged in a study of techniques for banking and preservation of skin for the treatment of burns, and has well-developed clinical research units for the study of shock patients and patients with head injuries. In the seventh school, approximately $50,000 a year is spent in research and training in emergency care.

When compared to the millions of dollars spent on other research in these institutions, the relative allocation of funds and efforts for the study of the acutely ill and injured is incredibly small. There has been a misconception that the acutely ill or injured cannot be adequately studied. Such a misconception has held back advances in critical-care medicine. These areas can and must be studied if progress in emergency health care is to be accomplished. The requirements for manpower and financial support are high.

Insurance Services

Approximately 1,000 insurance companies write casualty or indemnity insurance throughout the state. About 500 of these have offices within the state. These activities are

managed by the insurance department under the secretary of insurance of the governor's cabinet. The department, once every three years, examines all domestic insurers under a system established and operated by the National Association of Insurance Commissioners. It maintains a Bureau of Rate Regulation for fire, inland marine, casualty, title, life and accident, and health insurance as submitted by individual companies. It maintains bureaus for companies as well as for agents and brokers. In a sense, it regulates all insurance activities within the state including Blue Cross, Blue Shield, compensation insurance, and liability insurance.

It was estimated in 1968 that a loss of $22,600,000,000 resulted from deaths and injuries related to motor vehicle accidents, fires, and non-traffic accidents in the United States. In Pennsylvania, for the 793 deaths and 47,602 injuries for which compensation was offered, the total payments by state and private insurers was $81,865,000. While major payments were made by the private insurance companies and self-insurers, $5,828,000 in state funds were utilized.

Diseases Reportable to the Pennsylvania Department of Health

At the present time, the rules and regulations of the Pennsylvania Department of Health (Chapter III, Article 355), relative to communicable and non-communicable diseases (adapted pursuant to the provisions of the Disease Prevention and Control Law of 1955, the Act of April 23, 1956, P.L. 1510 as amended), indicate the following: "A reportable disease is any communicable disease declared reportable by regulation"... which in the opinion of the secretary may be a public health emergency. "Non-communicable diseases and conditions may be authorized as reportable in order to provide data and information, which, in the opinion of the advisory health board, are needed in order to effectively carry out programs of the department designed to protect and promote the health of the people of the Commonwealth or determine the need for the establishment of such programs."

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At the present time, there are forty-nine reportable communicable diseases in the state of Pennsylvania, ranging from "actinomycosis to yellow fever." The department also requires that any unusual or ill-defined disease, illnesses, or outbreaks should be reported to the local and state health officer. Included among these are a number of rarer diseases or illnesses. Trauma and heart attack which account for many more deaths are not reportable.

The selected non-communicable diseases and conditions considered reportable include any "bite" or injury resulting in a laceration or puncture of the skin and inflicted by an animal susceptible to rabies. Also, such non-communicable diseases and conditions are reportable if such reports are needed to enable the secretary to determine and deploy the most efficient and practical means to protect and promote the health of the people. Cancer is reported routinely from the counties of Allegheny, Philadelphia, Beaver, Washington, and Westmoreland, but from the rest of the state it is reported only when discovered as the result of mass chest x-rays or surveys.

It is apparent from this information that the Secretary of Health for Pennsylvania has within his power to survey, maintain a registry, and require reports relative to any problem, including highway accidents and injuries. He does not have the power to require autopsies of all such fatal injuries, although he does have the authority to require the reporting of those autopsies which are performed.

While at the present time, the Highway Safety Bureau and the Bureau of Traffic Engineering report injuries and fatalities within their bureaus, much data with references to type of injury and cause of death are missing. Most of the information collected relates to the position in the automobile of the individual injured or killed and whether or not the injury is considered minor, moderately severe, or potentially lethal. A particular defect in the current

reporting in Pennsylvania excludes those traffic victims who die in the hospital or following discharge from the hospital, except for those in Philadelphia or Allegheny County when such cases are reported to medical examiners or coroners.

As the result of the National Highway Safety Act of 1966, the National Highway Safety Bureau acknowledged that one of the major defects in planning for survival on American highways was the lack of appropriate information regarding the human element in traffic accidents. Despite four years of planning and working with state health and highway departments, as of April 15, 1970, no studies, registries, or continuing data systems have been devised and utilized to cover the phases of accidental death and injury on the highway from the time of the accident through the ultimate recovery or death of the individuals concerned. For the past two years, the department of transportation has sponsored accident investigation teams in each of the eleven highway districts of the state. The study has included, in part, the factors responsible for the accident but not the long-term effects on the survivors. A practicing physician has been added to the team (1971) only as a result of the interest of the Pennsylvania Committee on Trauma of the American College of Surgeons.

The National Research Council and its committee on Emergency Medical Services recommended in 1966 that trauma registries should be established as a mechanism for continuing "description of the natural history of the various forms of injuries" and that consideration be given to the establishment of a national computerized central registry. This group also recommended that studies on selected injuries (such as traffic injuries) be incorporated as reportable diseases under Public Health Service control.

On January 9, 1969, at the recommendation of the Commission on Emergency Medical Services of the Pennsylvania Medical Society, a document entitled, "Justification for Reporting Hospitalized Patients and Deaths from Traffic Accidents," was submitted to the advisory health board of the Pennsylvania Department of Health. No action has been taken.

The development of a registry for traffic injuries and deaths in Pennsylvania would provide data currently unavailable, yet seriously affecting survival on the highways of almost 200,000 Pennsylvanians injured annually. Such information would aid in determining the role of previous disease or drug abuse (including alcohol) in the causation of highway accidents.

Autopsy of the Traffic Fatality

Epidemiology of death from accidental injury can be determined only by a complete autopsy examination of the victim. Information obtained from the autopsy may aid in the prevention of similar catastrophic injuries or at least suggest changes in treatment. It is the responsibility of the coroner or the medical examiner to direct such autopsy examinations. Unfortunately, they are far from routine. In Pennsylvania, the highest autopsy rate for fatal injuries occurs in the urban areas. The Philadelphia Medical Examiner's Office autopsies the great majority of such deaths. Allegheny County has a similar rate but the highway safety groups report that autopsies are exceedingly rare; indeed, accurate reports of the mechanisms of injury are infrequent from the less populous counties of the State.

Autopsy studies of traffic fatalities in Michigan, if extrapolated to Pennsylvania, suggest that the Commonwealth might annually salvage an additional 10% (saving over 200 lives) if emergency services for highway victims were improved.

In 1966, the "Registry of Accident Pathology" was formed at the Armed Forces Institute of Pathology, primarily to collect information on fatal automobile accidents. An autopsy protocol has been developed by this group which is comprehensive and intended to document the injury and the circumstances surrounding the fatal accident. This computer protocol has been distributed to various crash investigation teams under the National Highway Safety Bureau and to interested individuals in the area of accident pathology.

The Coroner and Medical Examiner System

About 20% of all deaths in the United States are unattended by physicians. Certificates of Death can be issued only by licensed physicians, medical examiners who are licensed physicians, or coroners. While the coroners in Ohio and Louisiana must be physicians, this is not true throughout the country.

All 67 counties in Pennsylvania have a coroner or a medical examiner. Only a few counties have both a medical examiner and a coroner, and in two counties, these individuals are the same person. Coroners are equally divided into two groups of non-physicians and physicians and all are elected to office.

By law, the coroner is usually directed to "investigate the cause of any death which appears to have happened in the county regardless whereof the cause thereof may have occurred." Generally, this includes the following circumstances: (1) any sudden, violent, or suspicious death; (2) any death where no cause is properly certified by a person duly authorized to declare death; (3) any death resulting from a mine accident as directed by law; (4) deaths resulting from

drownings, cave-ins, and subsidence, or any death resulting from an accident regardless of the time elapse between the time of the accident and the time of the death; and (5) any stillbirth death of any baby dying within 24 hours after his birth, or the death of any prematurely born infant, wherein the cause of death is not properly certified by a person duly authorized thereto." Most regulations also indicate that when there is any doubt regarding the circumstances of death, the coroner should be notified.

For clarification of deaths occurring in the operating room, both Philadelphia and Allegheny Counties require or strongly recommend that all such operative deaths be immediately reported.

While information relative to the death of any individual registered in the coroner's office (and certified by the coroner) is public information and can be made available, tabulation of autopsied deaths from injury within the Commonwealth is incomplete and generally not available. The State Highway Safety Bureau reports considerable difficulty in obtaining reports from counties other than Philadelphia and Allegheny. Less than one-half of the reports of highway accidents in which the coroner has issued a certificate of death or performed an autopsy are available either to the Pennsylvania Department of Health or to the State Highway Safety Bureau.

Impartial Medical Testimony

In 1966, the Emergency Medical Care Committee of the NRS-NAS summarized (below) the physicians' current role as an aid to the judiciary system. In Pennsylvania, as across the nation, reform is needed.

"The courtroom sequelae of accidents are often, perhaps, generally dealt with in a manner below the general standards of the medical and legal professions. The courts for settlements of disability claims in some areas are provided with inadequate or inexpert evidence and judgment may well reflect response to social, emotional, or political pressures, rather than to sound medical testimony. In this respect, both lawyers and physicians for the claimants and for the defending insurance companies too often produce prejudiced medical testimony, diametrically and predictably contradictory. 'Expert Medical Testimony' under these circumstances has commonly lacked clinical expertise. A system has been adopted by the judiciary in a number of localities to provide impartial evaluation of disability by a panel of physicians who are expert in their given fields and paid either by the court or jointly by the parties involved. This mechanism has proved to be of great value, and should

be more universally employed. It is imperative that the physician's role be uninfluenced by socio-economic pressures."

First Aid Training for Licensed Drivers

The division of health mobilization and later the division of emergency health services of the U.S. Public Health Service has been largely responsible for training several million Americans in "Medical Self Help." This program has been designed to train one member of every family in basic first aid. It has recently been incorporated into the curriculum of many school systems. As demonstrated by the American Red Cross, such experience, particularly in terms of pulmonary resuscitation, may be effective in saving lives. More recently, the National Highway Safety Bureau has indicated that the drivers and passengers in motor vehicles should be encouraged to learn first aid in order to increase the salvage of individuals involved in highway accidents.

Recommendations

1. Governor Shafer should be complimented by the Pennsylvania Medical Society on his creation of a task force for planning of emergency health services under the advisory council for Comprehensive Health Planning. Governor Shapp should transform this task force into an executive council on Emergency Health Services, responsible directly to his office. This council should include representatives of appropriate professional and technical disciplines as recommended by the American Medical Association, as well as the departments of health, insurance, transportation, welfare, and police. This council should be given the immediate responsibility for implementation of an effective system of response to medical emergencies, not only on the highways but across the many political subdivisions of the state.

2. The Pennsylvania Medical Society, the Commonwealth of Pennsylvania, the Hospital Association of Pennsylvania, and the Pennsylvania Ambulance Association should join in sponsoring the development of community councils on emergency medical and health services at local levels. The state council should be responsible for coordination of local councils.

3. The Commonwealth of Pennsylvania, through the governor's highway safety task force should provide financial support for the operation of each local council.

4. The Pennsylvania Medical Society, the Pennsylvania Ambulance Association, the Hospital Association of Pennsylvania, and the Pennsylvania Department of Health should join in the development of a newsletter on emergency medical services, designed to provide an interdisciplinary means of communication between community councils and related services and individuals. The newsletter should serve, in part, as one mechanism of informing the physician, the public, and the legislative and governmental leaders that all emergency medical and health services of Pennsylvania need to be improved.

5. The Pennsylvania Assembly should pass appropriate legislation and funding to enable the Secretary of Health to develop standards for licensing of all ambulance services. The secretary should also be directed to develop training requirements for ambulance attendants and require certification and registration of all such attendants. This legislation and the resulting standards should insure the legality and the capability of the ambulance attendant to initiate all necessary life support prior to the victim's reaching definitive medical care.

6. Equipment and vehicle design of all ambulances providing emergency medical and health services should be in accord with those recommendations of the National Academy of Engineering and National Academy of Sciences-National Research Council.

7. Ambulance vehicles should not only be licensed and regularly inspected but the inspection should include the equipment.

8. The Pennsylvania Medical Society, the Pennsylvania Ambulance Association, and the Pennsylvania Department of Health with the advice of the Hospital Association of Pennsylvania should develop a standard ambulance form for the identification of the patient, a description of his problem, condition, care, and transportation. The forms should be completed by ambulance attendants for each patient and a copy of each form should be made a part of the patient's clinical hospital record.
9. The Pennsylvania Ambulance Association, the Pennsylvania Department of Health, and the Hospital Association of Pennsylvania should promote the principle of interchange of equipment and supplies (e.g. stretchers) between ambulances and emergency departments.

10. The secretary of health should be empowered by appropriate legislation to insure that all licensed ambulances and hospitals include the capability of two-way voice communications between the ambulances and nearby hospitals.

11. The governor should initiate the development of a state-wide emergency communication system. The governor should request the president of the United States to adopt the civil defense communication system in Pennsylvania to day-to-day emergency communications as a pilot experiment for the nation.

12. The governor should take the steps necessary to the state-wide implementation of the concept of the single emergency telephone number (such as the 911 system) integrating ambulance, hospital, police, fire, poisoning, and related services.

13. Insurance companies, including Blue Cross and Blue Shield, should develop broad plans for paying for ambulance services as well as emergency services wherever rendered.

14. Consideration must be given to subsidizing 24-hour ambulance services by contract or other financial arrangement where adequate volunteer or community ambulance services do not exist. The responsibility for providing ambulance service or seeing that adequate ambulance service is provided should be placed upon county governments.

15. Hospital-based ambulance services should be encouraged for selected category I and II hospitals. Ambulance attendants (emergency medical technicians) may be a part of these hospital staffs allowing participation in audits, conferences, and other teaching mechanisms for improvement of emergency services.

16. The Pennsylvania Medical Society, the Pennsylvania Ambulance Association, and the Hospital Association of Pennsylvania should jointly sponsor the development, at least monthly, of morbidity and mortality review conferences between related hospitals and ambulance services. These conferences would be designed to improve the quality of care and services by joint analysis of current experiments.

17. Each ambulance service should have a physician advisor or be formally associated with one or more hospitals in an educational program.

18. The Pennsylvania Medical Society, in cooperation with the Pennsylvania Department of Health and the Pennsylvania Ambulance Association, should develop guidelines for the physician's responsibility, authority, and legal liability at the scene of extra hospital medical emergencies.

19. The Pennsylvania Department of Health, with the advice of the appropriate health organizations, should institute a uniform system of reporting emergency department visits. The data collected by these reports should be compiled and analyzed by the department of health and published annually to the health and insurance professions.

20. A complete list of poison control centers should be made available to all physicians, hospitals, paramedical personnel, police, and ambulance services. A centrally located statewide poison control center should be established by the Pennsylvania Department of Health to coordinate existing local centers and to serve areas not presently covered.

21. Those emergency departments with consulting psychiatrists and psychiatric facilities should be registered and the information made available to all hospitals, physicians, and ambulance services, as well as to the public.

22. The Pennsylvania Medical Society in collaboration with the Pennsylvania Department of Health and the Hospital Association of Pennsylvania should survey and categorize the emergency facilities of hospitals within the state in accordance with national standards now being developed by the National Academy of Science-National Research Council and the American Medical Association. The resultant categorization of hospitals should be published by the Pennsylvania Medical Society, the Pennsylvania Ambulance Association, and the Hospital Association of Pennsylvania.

23. The Pennsylvania Medical Society, the Hospital Association of Pennsylvania, and the Pennsylvania Departments of Health and Welfare should initiate the upgrading or creation of new facilities in those areas where adequate emergency care is not available.

24. The secretary of Health should take the necessary steps to assure that highway injuries and all accidental deaths are made reportable diseases in Pennsylvania. These reports should include sufficient data to permit an assessment of the cause of the accident and the injury, the extent of the injury, and the outcome as to life or death. Sufficient data should be provided to permit monitoring of the effectiveness of the response of the emergency care system.

25. The secretary of Health should make drug poisoning a reportable disease in Pennsylvania.

26. All victims dying as a result of automobile accidents in Pennsylvania should be autopsied. Legislation requiring coroners and medical examiners to carry out such examinations should be passed by the Pennsylvania Assembly. Uniform coding and analysis similar to that provided by the Armed Forces Institute of Pathology and its Registry of Accident Pathology should be utilized. Reports of such autopsies should be compiled and analyzed in an annual assessment by the Pennsylvania Department of Health and such information should be widely disseminated to the health profession, the insurance, and automobile industries.

27. The Pennsylvania Medical Society should initiate a program that would result in the adoption of the medical examiner system, in place of the coroner system, throughout the State. Where desirable, the medical examiner's office should be organized on a regional basis.

28. The Pennsylvania Medical Society should initiate those steps necessary for the utilization of impartial medical testimony throughout the judiciary system.

29. The critical need for research in emergency medical and health care should be brought to the attention of the secretary of health of the Commonwealth, the deans of the medical colleges, the clinical departmental chairmen within the teaching hospitals, and to the

directors of insurance companies having headquarters within the state. The councils on emergency medical services throughout the state should be requested to join in seeking funds for support of research in emergency medical care. The secretary of health should request financial support from the Commonwealth for research in emergency medical services. The insurance industry within the state should be requested to provide financial support for research in emergency medical services. The American Trauma Association, paralleling the American Heart Association, and the American Cancer Society, should be activated and a Pennsylvania chapter organized and encouraged to provide research support. Research on emergency medical services should be promoted by a service under the state council on emergency medical services. This service should provide information on available research support and assistance in obtaining financial support. Consideration should be given to pilot studies such as telemetry of physiological data and the use of audiotapes, photography, and helicopters by ambulance services.

30. Basic first-aid instruction, such as provided by the American Red Cross, should be taught in all schools and should be a requirement for driver licensure in the Commonwealth.

31. In order to promote the foregoing recommendations, the Pennsylvania Medical Society should publish this report and distribute it widely to the emergency health disciplines.

32. The Pennsylvania Medical Society should join with the Pennsylvania Department of Health, the Hospital Association of Pennsylvania, the Pennsylvania Committee on Trauma of the American College of Surgeons, and the Pennsylvania Ambulance Association in the development of a state-wide conference designed to promote the development of emergency medical and health councils. This conference should be held in 1971 and consideration should be given to a follow-up conference as necessary.

33. The Pennsylvania Medical Society, the Hospital Association of Pennsylvania, the Pennsylvania Department of Health, and the Pennsylvania Ambulance Association should hold additional state-wide congresses on emergency medical services, inviting all disciplines to participate, in an effort to implement the above recommendations. They should request the governor to sponsor a conference on emergency medical care for this purpose.

34. The relationship of drug abuse, including alcohol abuse, to traffic accidents should be carefully studied. Present laws concerning such drugs and driving should be strictly enforced and new laws promulgated as needed to assure the public that the chronic abuser is able to obtain proper medical and psychiatric treatment.

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PENNSYLVANIA MEDICINE cardiovascular brief

The Heart and Chronic Obstructive Pulmonary Disease—COLD. Part I

Harry Shubin, M.D., F.A.C.P., Medical Director and Administrator of Center City Hospital, Philadelphia, is questioned by William G. Leaman, Jr., M.D.

What is C.O.L.D.?

This broad definition includes pulmonary emphysema, chronic bronchitis, asthma, and pneumoconiosis. Varied interpretations and nomenclature, depending on clinical, anatomic, pathologic, or physiologic views, have led to confusion in the analysis of morbidity and mortality data.

What is the disease spectrum?

It ranges from "pure" chronic bronchitis with no emphysema through variable degrees of bronchospasm (allergic, etc.), anatomic emphysema to severe emphysema, with or without significant bronchitis.

How are the clinical/pathologic/physiologic types differentiated?

The American Thoracic Society and College of Chest Physicians have described them as follows: (1) **Chronic bronchitis** is characterized by excessive mucus secretion in the bronchi with chronic recurrent cough (arbitrarily for a minimum of three months of the year and for at least two successive years), in patients with no other pulmonary pathology. It is a common, but not necessary, forerunner of pulmonary emphysema. (2) **Asthma or allergic bronchitis** is characterized by an increased reaction of the trachea and bronchi to various stimuli with narrowing of the airways. When persistent airway obstruction is present, we have a C.O.L.D. patient. (3) **Pulmonary emphysema** has been defined in clinical, radiologic terms, but is best described morphologically. It is an anatomic alteration of the lungs characterized by an abnormal enlargement of the air spaces distal to the terminal non-respiratory bronchiole, accompanied by destructive changes in the alveolar walls. The pathologic classification of emphysema refers to paracicatricial (adjacent to fibrotic lesions of the lung) or lobular (centrilobular or perilobular), depending on the site of the dilated airspaces.

How common is this entity?

The incidence and mortality of patients with C.O.L.D. have increased spectacularly in recent years. The reported deaths have risen from 2,300 in 1945 to 20,000 in 1964, and to more than 30,000 in 1970. Morbidity figures, as indicated by statistics of the Social Security Administration worker disability allowances, report emphysema as the second most frequent cause of disability, topped only by arteriosclerotic heart disease.

Are there many etiologic factors?

Yes, and one must recognize these factors, both for preventive and therapeutic management: (1) **Smoking** is a demon, increasing airway resistance and causing diminution or loss of ciliary activity. (2) **Infection:** Repeated upper and lower respiratory tract infections hasten the development of destructive lung disease. (3) **Air pollution** and **occupation:** The increase in air pollution is of growing concern and only recently have control measures been organized. Silicosis and other pneumonioses impair pulmonary function by air flow obstruction. (4) **Allergy:** Although this has not been definitely demonstrated as a primary cause of chronic obstructive pulmonary disease, it is certainly a contributory factor. (5) **Hereditary conditions**, such as mucoviscidosis, alpha antitrypsin deficiency, etc., must be considered. (6) **Aging**, with its decrease in elasticity of lung tissue, is also important.

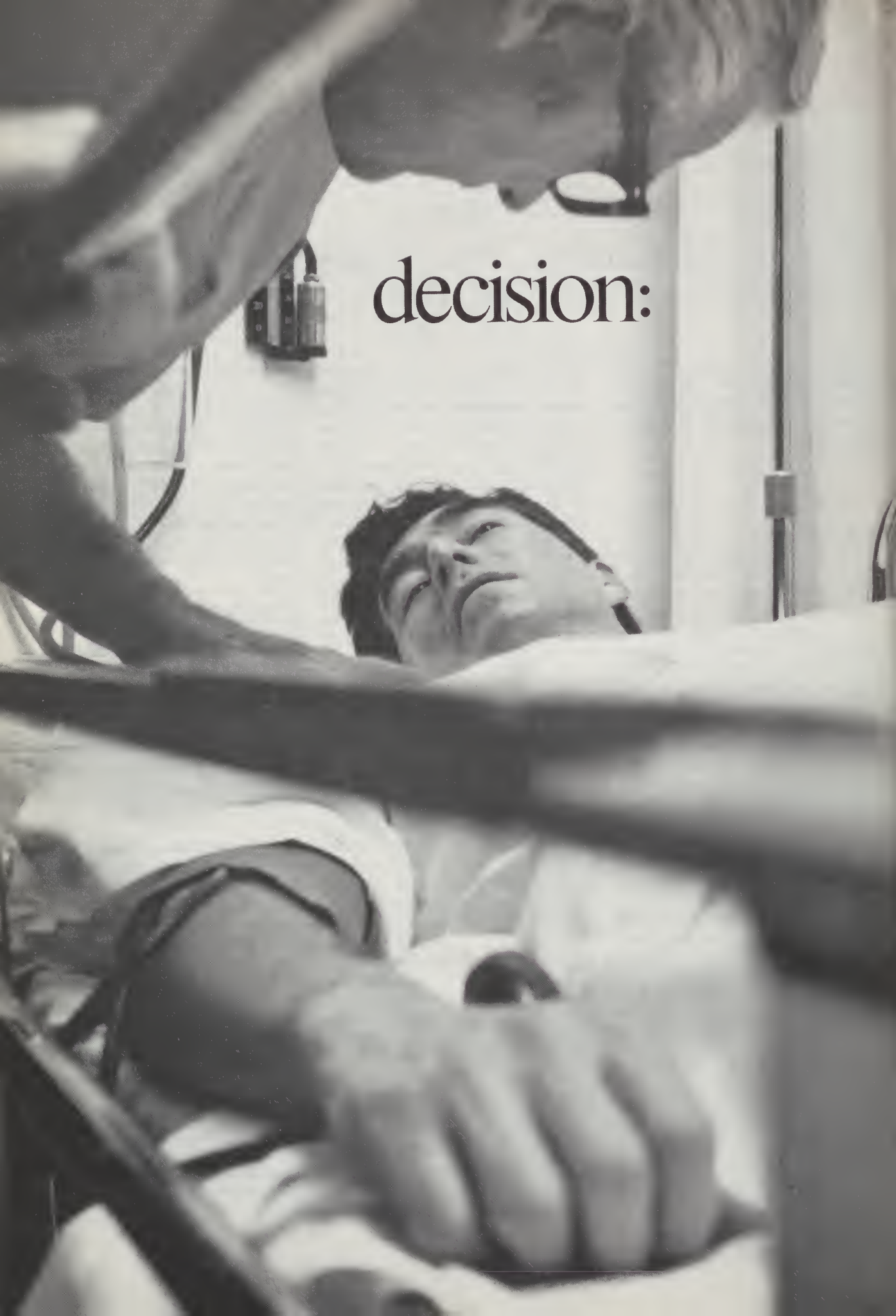
How does the physician begin the management of these patients?

First, it is essential always to consider chronic obstructive pulmonary disease in any patient with a persistent cough with dyspnea. Early diagnosis can prevent or reverse pathologic changes. Even diagnosis at a later date still allows effective therapy, which could prevent or delay cardiac complications.

Do pulmonary function studies help?

Very definitely! Vital capacity, forced expiratory volume in one, two, and three seconds, and maximum voluntary ventilation studies can be done easily in most hospitals or doctors' offices with relatively simple equipment. These tests can detect early physiologic changes before symptoms develop, can differentiate cardiac from pulmonary origin of dyspnea, and can establish a base line to help follow the course and the effect of therapy and reversibility of the disease.

William G. Leaman, Jr., M.D., edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.


decision:

Loridine® I.M.
Cephaloridine

1.5 to 3 Gm. daily successfully treats many moderately severe infections*

- indicated for use against susceptible organisms causing:
  pneumonias following surgery
  abscesses
  wound infections
  infections following compound fractures
  urinary tract infections
- relatively painless I.M. injection
- logical I.M. follow-up to I.V. cephalosporin therapy

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

Lilly 101041

Loridine® CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

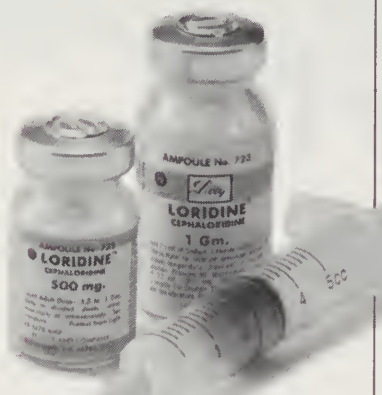
Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Loridine®
CEPHALORIDINE



Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms, and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169]

Additional information available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

Lilly

000904

Cancer Progress -1970

The recently published annual report of the American Cancer Society is a fascinating and enthralling story. For more than fifty years this combination of professional and lay volunteers has developed and maintained an enveloping attack on cancer. If one can speak of a report as having an "air" it would be one of confidence. The society is hoping that Congress will make cancer control a national priority and provide funds for a massive, goal-oriented research effort. The wisdom of such a move, of course, is moot.

Regardless of the congressional outcome, the society has good reason for its confidence in medicine's ability to conquer cancer and feels that progress in the 70's will parallel that of the 1880's when the major infectious diseases were brought under control. Leukemia control has reached the point where fifteen years' survival is not uncommon. Virus research and immunology are promising the development of a vaccine. Instead of trying to focus research into one avenue, a multiplicity of approaches are supported— a policy well-suited to such a multiple-disease entity such as cancer.

In addition to its support of basic research, attention is called to its clinical investigation program designed to bring research findings to the patient as quickly as possible. Support of a cooperative study to verify Gold's work in Montreal and Grossi's occult blood studies are examples of the program. There is also the far-sighted support of programs in high schools to encourage youth to seek careers in biomedical fields.

Professional education has always been a major effort of the American Cancer Society. Publications, films, and exhibits are available and continually up-dated. Symposia, conferences, and workshops are supported throughout the country. Last year more than three quarters of a million physicians, dentists, nurses and allied professionals attended 27,000 such meetings.

Public education is likewise covered with pamphlets, films (usually accompanied by a volunteer physician), health fairs, church and women's club meetings. The Society counted 15 million people reached by 200,000 such programs in 1970.

Service to the cancer patients has also grown in size and extent. In an effort to improve the quality of survival, the rehabilitation program was initiated. Breast amputees, ostomy groups, and laryngectomees are all served under this program. Multiphasic screening, free breast and Pap tests are sponsored as pilot studies in rural and other areas.

In these troubled times it is refreshing to see what dedicated volunteers can do to control this disease. A red rose of honor to the American Cancer Society.

CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Frederick L. Hartmann,** Philadelphia; University of Pennsylvania Medical School, 1918; age 78; died December 29, 1970. Dr. Hartmann was senior consultant in medicine at Lankenau Hospital at the time of his death. He had been chief of medicine there for more than twenty years. He did extensive research in leukemia, and was a fellow of Philadelphia College of Physicians and Surgeons.

○ **Theodore K. Harveson,** Philadelphia; Temple University School of Medicine, 1940; age 58; died December 29, 1970. His wife, one daughter, two sons, and two sisters survive.

○ **Archibald M. Cook,** Williamsport; University of Pennsylvania School of Medicine, 1918; age 82; died December 18, 1970. No survivors are known.

○ **Samuel N. Comens,** Bethlehem; University of Vermont College of Medicine, 1925; age 71; died December 31, 1970. Survivors are his wife, and two daughters.

○ **Paul J. Bamberger,** Bethlehem; University of Colorado School of Medicine, 1936; age 64; died December 25, 1970. A member of the American Academy of Occupational Medicine, he was assistant to the medical director at Bethlehem Steel Corporation. His wife, two daughters, a son, and a sister survive him.

○ **Charles Bordin**, Philadelphia; Temple University School of Medicine, 1929; age 65; died March 10, 1971. He is survived by his wife, two daughters, a son, and two brothers.

○ **William T. Chain,** Narberth; Jefferson Medical College, 1939; age 56; died March 4, 1971. His last 15 years were spent on the staff at Bryn Mawr Hospital. Survivors include his wife, two daughters, three sons, a brother, and a sister.

○ **John R. Donoghue**, Pittsburgh; Georgetown School of Medicine, 1935; age 76; March 19, 1971. He was physician for the city of Pittsburgh. He is survived by one sister.

○ **William T. Ellis,** Philadelphia; University of Pennsylvania School of Medicine, 1906; age 90; died December 1, 1970. No survivors are listed.

○ **Bernard J. Johnston**, Pittsburgh; Stritch School of Medicine, Loyola University; 1932; age 63; died February 20, 1971. In addition to his general practice, he was a neurologist for the Veterans Administration and Woodville State Hospital. He is survived by his wife and two sisters.

○ **Louis M. Kochin,** Pittsburgh; Northwestern University Medical School, 1925; age 72; died March 9, 1971. Dr. Kochin, who was a pediatrician, was also an ordained rabbi. He is survived by his wife, two daughters, and three sisters.

○ **Moses Kopeika**, Miami Beach, Fla.; University of Pennsylvania School of Medicine, 1922; age 76; died March 4, 1971. He was a physician in the Philadelphia area for 45 years. Dr. Kopeika had received a presidential citation for 25 years of medical service to the Selective Service Board of Philadelphia. Survivors include his wife, two daughters, and a son.

○ **Saul X. Kramer**, Pittsburgh; University of Pittsburgh, 1925; age 59; died March 17, 1971. He was a general practitioner in Pittsburgh for 35 years. He is survived by his wife, a daughter, two sons, and two brothers.

○ **Edmund V. Matys**, Dupont; Jefferson Medical College, 1933; age 62; died March 14, 1971. Surviving are his mother, one son, one sister, and a brother.

○ **William A. McHugh, Jr.**, Uniontown; University of Pennsylvania School of Medicine, 1911; age 83; died March 6, 1971. He had been a consulting surgeon at the Uniontown Hospital. He is survived by his wife and four daughters.

○ **Robert W. McLaughlin**, Easton; University of Pennsylvania School of Medicine, 1949; age 48; died March 19, 1971. He was president of the Northampton County Medical Society in 1968. The Easton Kiwanis Club gave him an International Service Award for his volunteer service in a South Vietnamese hospital in 1968. Survivors are his mother and his wife.

○ **John L. Miller**, Ft. Lauderdale, Fla.; University of Pittsburgh School of Medicine, 1912; age 82; died March 13, 1971. Before his retirement in 1969, he had practiced in West Aliquippa for more than fifty-six years. He is survived by his wife, two daughters, and a son.

○ **Abdullah K. Sallom**, Upper Darby; Temple School of Medicine, 1909; age 81; died December 28, 1970. He is survived by his wife.

○ **George C. Schein**, Pittsburgh; University of Pittsburgh School of Medicine, 1933; age 62; died March 4, 1971. Dr. Schein was director of medical education in otolaryngology at Eye and Ear Hospital, Pittsburgh. Besides his wife, he is survived by a daughter, two sons, one of whom is Maj. George Schein, M.D., a brother, and a sister.

○ **Bernard P. Widmann**, Philadelphia; Medico-Chirurgical College in Philadelphia, 1916; age 80; died February 26, 1971. He was formerly director of the department of radiology at Philadelphia General Hospital, Fitzgerald Mercy Hospital, and Our Lady of Lourdes Hospital in Camden. He had served as president of the American Roentgen Ray Society in 1950, and as president of the American Board of Radiology.

James Kenneth Gordon, Fayetteville; Hahnemann Medical College, 1917; age 79; died March 17, 1971. Dr. Gordon served as a staff member at Samuel G. Dixon State Hospital until his retirement in 1967. He is survived by a son.

William H. Hermanutz, Philadelphia; Jefferson Medical College, 1928; age 67; died February 19, 1971. He was a medical examiner for the Reading Railroad. He is survived by two daughters.

Joseph S. Kenney, Philadelphia; University of Pennsylvania Medical School, 1922; age 78; died March 8, 1971. He was a retired medical director of the parochial school system for the Philadelphia Board of Education. He is survived by a son and two brothers.

PHYSICIANS WANTED

Approved General Practice Residency, available July 1, 1971. 274-bed accredited general hospital. ECFMG Certification required for foreign physicians. Write: Administrator, Lower Bucks Hospital, Bristol, Pennsylvania 19007.

Emergency Room Physicians - Busy emergency room; fee for service with hourly guarantee; vacation; one of group leaving for residency; wish to expand to five men. Write or call Administrator, Lee Hospital, Johnstown, Pa. 15901. Phone: (814) 535-7541.

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General practitioners badly needed in Columbia County, Pa. Peaceful college community and county seat on Interstate 80. Modern accredited hospital, all specialties handy. Income limited only by energy. Due to recent deaths of five physicians, office space readily available. Reciprocal coverage and part-time salaried positions available. No investment needed. Contact President, Columbia County Medical Society, C. Perry Cleaver, M.D., Catawissa, Pa. 17820.

Wish to locate in area with long-established practices now open? Death has reduced our number. Hospital medical staff and community will welcome any qualified G.P., OB-GYN or internist wishing to locate. Approved 82-bed, short term hospital. Expect to build new plant in near future. Address inquiries to President, Medical Staff, Adrian Hospital, Punxsutawney, Pa. 15767.

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Physicians Wanted: Urologist, Orthopedic Surgeon, Pediatrician, Internist, Otolaryngologist, and General Practitioners. 250-bed fully accredited, expanding hospital. College town in central Pennsylvania with huge recreational dam under development. Offices available, attractive guarantee. Contact R. E. Cummings, Blair Hospital, Huntingdon, Pa. Telephone (814) 643-2290.

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start with DBI®-TD (phenformin HCl)

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Lowers elevated blood sugar without increasing endogenous insulin secretion.

Probably, secondary to its hypoglycemic effect, decreases insulin oversecretion. This may help to reduce lipogenesis and facilitate lipolysis, which may account for the clinically reported loss of excess body weight and lowering of elevated serum cholesterol levels in overweight, hypercholesteremic, stable adult diabetics unresponsive to diet alone.

DBI®-TD
(phenformin HCl)
timed-disintegration capsules 50 mg.

lowers elevated blood sugar

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To start with DBI-TD

Week 1 1 capsule with breakfast may be effective, or a second capsule may be given with the evening meal.

Week 2 Continue effective DBI-TD dosage.

If necessary, add an additional capsule to the A.M. or P.M. dose.

Thereafter Continue effective DBI-TD dosage.

To transfer from sulfonylurea therapy to DBI-TD alone: The first week, withdraw sulfonylurea; start with DBI-TD as indicated in the chart.

To transfer from sulfonylurea therapy to combined therapy with DBI-TD: The first week, continue dosage of sulfonylurea; add DBI-TD as indicated in the chart. When effective regulation of diabetes is attained, sulfonylurea may be reduced and/or withdrawn.

Indications: Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary. **Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes that is uncomplicated and well regulated on insulin; acute complications of diabetes (metabolic acidosis, coma, infection, gangrene); surgery; severe hepatic disease; renal disease with uremia; cardiovascular collapse, after disease states associated with hypoxemia. **Warning:** Use during pregnancy is to be avoided. Until adequate data on the effects of DBI on the human fetus are available, such use can be considered experimental. **Precautions: Starvation Ketosis,** which must be differentiated from "insulin lack" ketosis, and is characterized by ketonuria in spite of relatively normal blood and urine sugar, may result from excessive DBI therapy, excessive insulin reduction or insufficient carbohydrate intake. Adjustment of DBI-TD or insulin dosage, or supplying carbohydrates, alleviates this state. DO NOT GIVE INSULIN WITHOUT FIRST CHECKING BLOOD AND URINE SUGARS. **Lactic Acidosis:** DBI is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, it is recommended that periodic determinations of ketones in the blood and urine be made in diabetics previously stabilized on DBI, or DBI and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH and the lactate-pyruvate ratio. DBI should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis. **Hypoglycemia:** Although hypoglycemic reactions are rare when DBI is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with DBI. **Adverse Reactions:** Principally gastrointestinal, occurring more often at higher dosage levels; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, DBI should be immediately withdrawn. Although rare, urticaria and gastrointestinal symptoms following excessive alcohol intake have been reported. **Dosage:** 1 to 3 DBI-TD 50 mg. capsules daily. **FSN 6505-724-6331. Also Available:** DBI tablets 25 mg. **Supplied:** Bottles of 100 and 1000.

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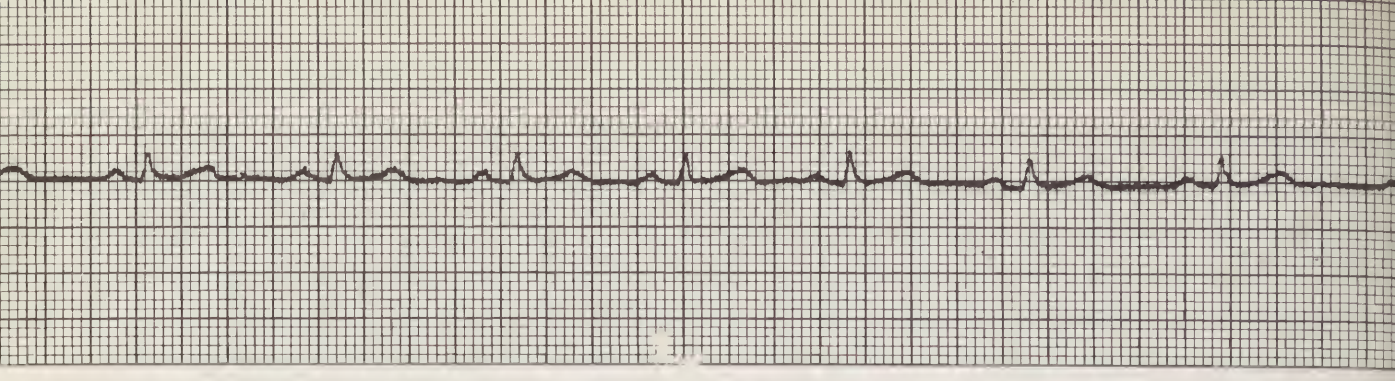

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose™ packages of 1000.

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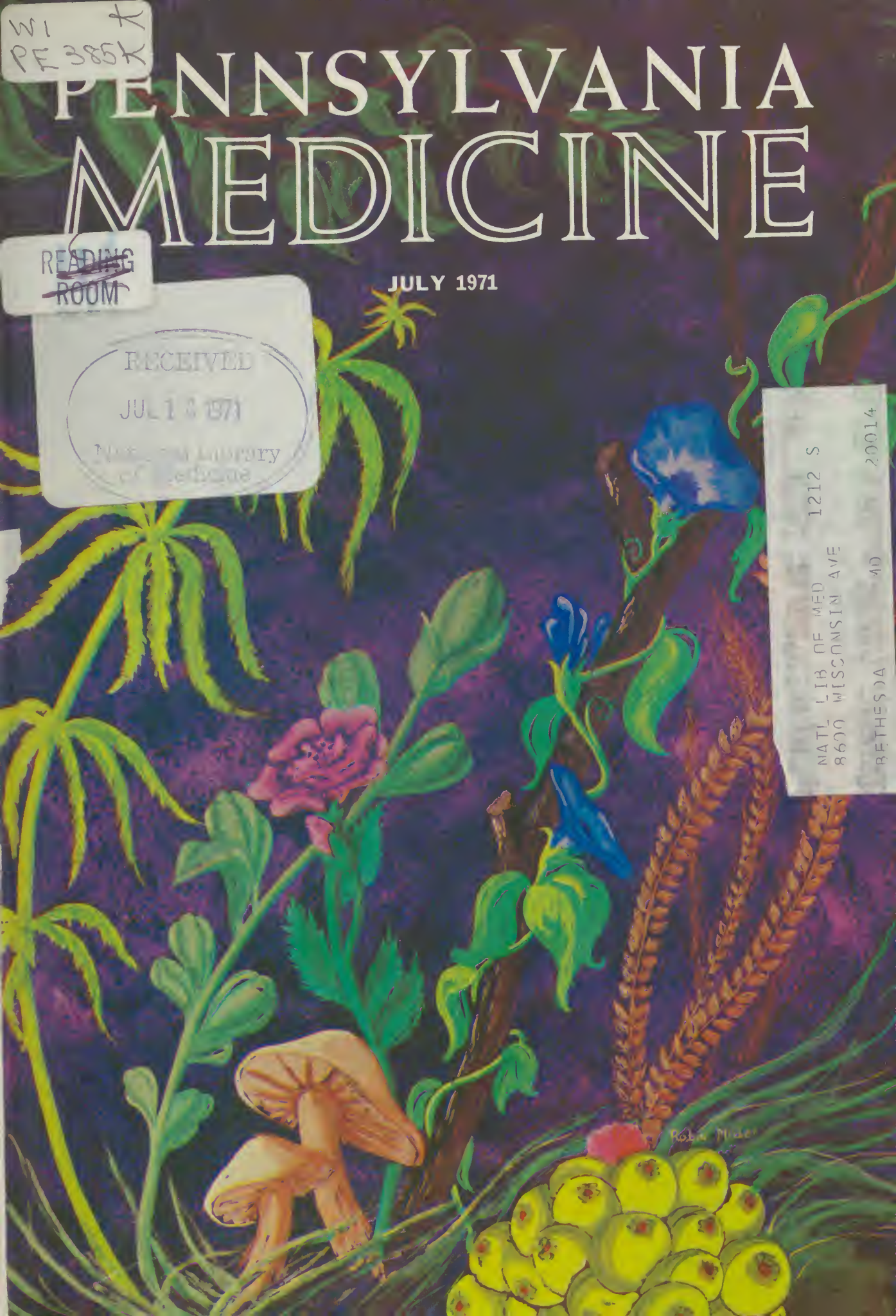
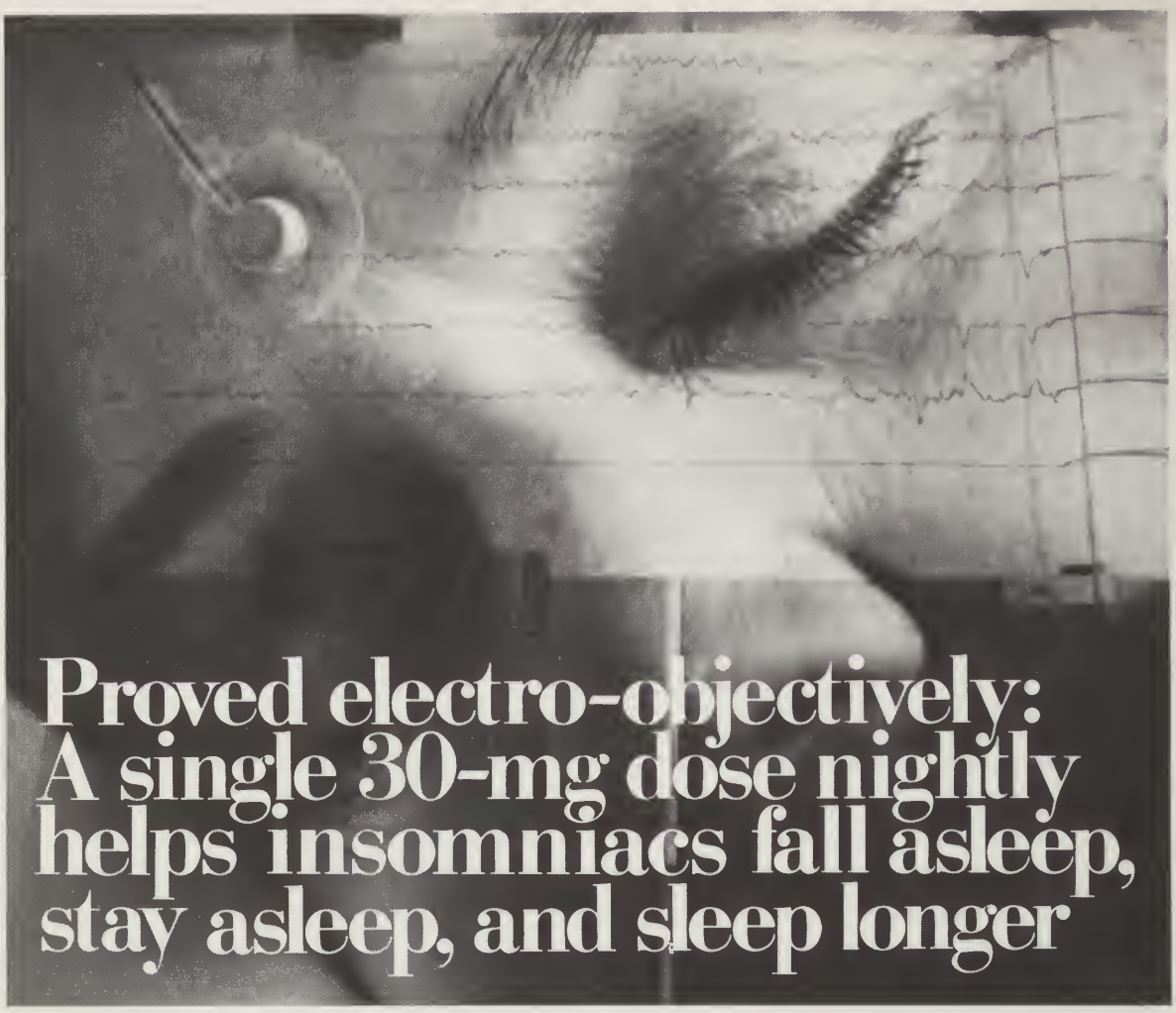




Proved electro-objectively: A single 30-mg dose nightly helps insomniacs fall asleep, stay asleep, and sleep longer

Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.[1,2,3]

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,[1] Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

Confirmed clinically

Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

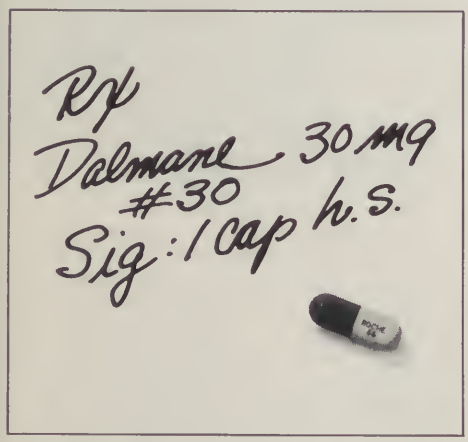
Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.

In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

Dalmane (flurazepam HCl) is generally well tolerated

In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.[3] Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

References: 1. Kales, A., *et al.:* "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. **2.** Kales, A., *et al.:* "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology,* Phila., Lippincott, 1969, p. 331. **3.** Data on file, Medical Department, Hoffmann-La Roche Inc.



Before prescribing, please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.,* excitement, stimulation and hyperactivity, have also been reported in rare instances.

For the sleep your patients need

New **Dalmane®**

(flurazepam hydrochloride)

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

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Journal of the Pennsylvania Medical Society

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In edema and hypertension.

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Hygroton® chlorthalidone USP

Makes water, not waves.

lectrolyte imbalance may occur when using diuretics. Hygroton is contraindicated in severe renal or hepatic diseases and, of urse, if it causes hypersensitivity. Carefully supervise those who may be receiving other antihypertensives.

Hygroton® chlorthalidone USP *Indications:* Hypertension and many types of edema involving retention of salt and water. *Contraindications:* ypersensitivity and most cases of severe renal or hepatic diseases. *Warnings:* With the administration of enteric-coated potassium supplements, which ould be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and rforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium pplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant women and rsing mothers since the drug crosses the placental barrier and appears in cord blood and since thiazides appear in breast milk. The drug may result tetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus. *Precautions:* Antihypertensive therapy with this drug should always be titiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. *Adverse Reactions:* Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization. *Average Dosage:* 50 or 100 mg. with breakfast daily or 100 mg. every other day. *How Supplied:* White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000. (B)46-230-G *For full details, please see the complete prescribing information.*

CIBA-GEIGY Pharmaceuticals, Division of CIBA-GEIGY Corporation, Ardsley, New York 10502

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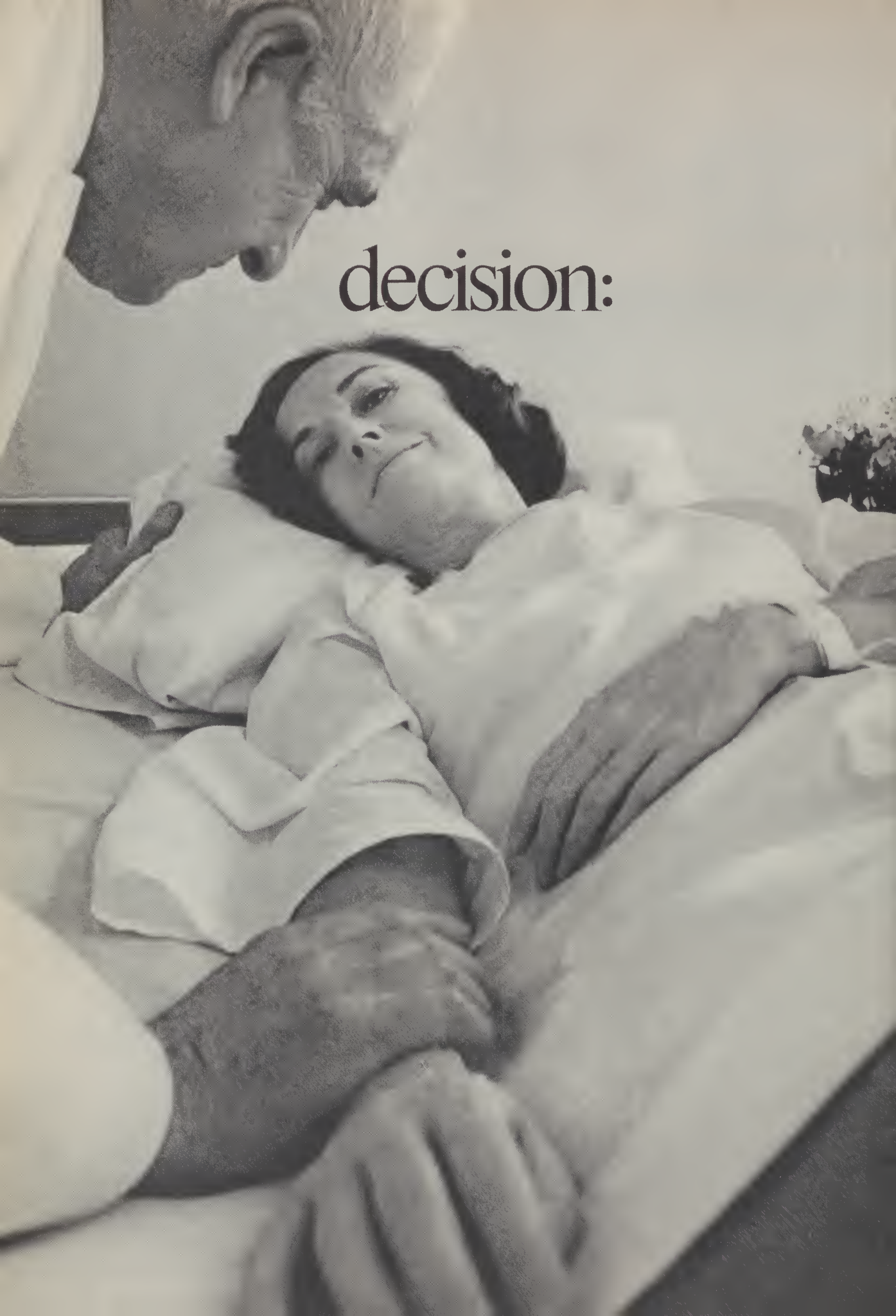
decision:

Loridine® I.M.
Cephaloridine

1.5 to 3 Gm. daily successfully treats many moderately severe infections*

- indicated for use against susceptible organisms causing:
  pneumonia
  urinary tract infections
  septicemia
  abscesses
- relatively painless I.M. injection

*due to susceptible organisms

Special Recommendations

Before Administration of Loridine

1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

Lilly 100913

Loridine® CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult dose) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber stoppered; 1 Gm., 10-ml. size, rubber stoppered. [0821]

Additional information available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

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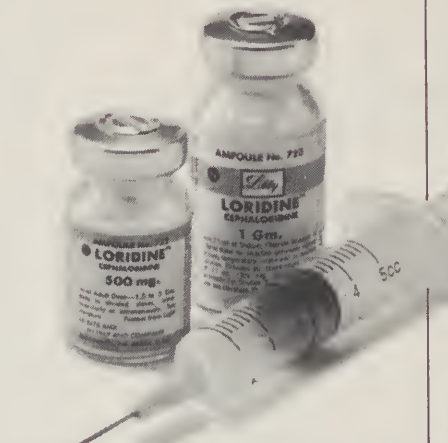
Loridine®
CEPHALORIDINE



Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

The least expensive* erythromycin has a brand name

Upjohn has reduced the price of E-Mycin® (erythromycin, Upjohn) by 25% following a change in manufacturing facilities. That makes E-Mycin the lowest priced* erythromycin on the market. Now your patients can have an Upjohn drug and save money besides.

*Prior to June 1, 1971

E-Mycin®

250 mg. tablets

(erythromycin, Upjohn)

Upjohn The Upjohn Company Kalamazoo, Michigan 49001

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70-9803

At last-an answer to your malpractice protection anxiety.

An insurance program sponsored and supported by the PMS.

The Pennsylvania Medical Society has been increasingly concerned about the problems faced by its members in securing and retaining professional liability insurance. There has been a growing tendency for insurance carriers to arbitrarily cancel, or not renew, professional liability insurance contracts for reasons entirely beyond the physician's control.

The obvious answer had to be a program, sponsored by the Pennsylvania Medical Society, designed to provide its members with *long term* coverage, adequate limits, at the best possible cost, in addition to giving the Society an opportunity to participate in the policy-making and administration of the program.

Such a program, more progressive and comprehensive than any that has been made available to any medical group, now exists. It is being underwritten by the Argonaut Insurance Company, a well established, "A+AAAA" rated casualty insurance carrier with assets in excess of $180,000,000 and considerable experience in the medical liability field. The exclusive, full-time administrator of the program is Parker & Co. Inc. of Pennsylvania, one of the country's leading insurance brokerage firms.

In review, the major points of the program are:

1. The Pennsylvania Medical Society has entered into an agreement with the Argonaut Insurance Company to administer the program through Parker & Co., Inc. of Pennsylvania.
2. The Argonaut Insurance Company will be bound to make this program available for a *minimum of five years. No* other carrier has offered such an agreement.
3. The Society participates through a Professional Liability Insurance Commission consisting of twelve members. The Commission will be the ultimate authority in appeals stemming from disputes between member insureds and will work in close conjunction with the local district committees.
4. No member's application will be declined except by the *joint decision* of the PMS Commission and the Argonaut Insurance Company.
5. Full liability coverage of $100,000 for each claim with an annual aggregate limit of $300,000 with excess limits up to $1,000,000 available. Coverage *is* available for interns, residents and physicians' and surgeons' assistants.
6. Rates are competitive with other major writers of professional liability insurance in Pennsylvania.
7. There is no requirement that a member purchase ancillary insurance coverages (homeowners, auto, etc.) in order to participate.

This program offers PMS members a unique opportunity to stabilize their professional liability insurance coverage on a long term basis. However, a broad based, high degree of membership involvement is essential to make this program a success. Please fill out the coupon indicating your interest in participating in the PMS endorsed program when your present coverage expires.

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Name_____

Office Address_____

Telephone No. _____

Medical Specialty_____

Date your professional liability insurance expires _____

Present Carrier _____

I am interested in participating in the PMS Professional Liability Insurance Program. Please send me an application. ☐

COUNCIL ON GOVERNMENTAL RELATIONS TAKES POSITIONS The Council on Governmental Relations met last month to consider bills of concern to physicians, and took positions on certain measures. Following is a brief description of each bill considered and the action taken by the council.

ABORTION S-617 Would permit abortions under limited and specific circumstances.(Oppose)
H-536 Would permit any woman the right to an abortion prior to the completion of sixteen weeks of pregnancy, in an accredited hospital or medical facility, not requiring any doctor or hospital to carry out an abortion against its or his or her will. (Oppose)
H-800 Would declare that all abortions under any circumstances are illegal. (Oppose)
ADVERTISING H-526 Would prohibit any person licensed to practice any healing art to solicit patients or advertise his services. (Support)
BLOOD H-220 "Pennsylvania Blood Bank Act" - Would permit the Department of Health to regulate and license blood banks. (Deferred Action)
CHIROPRACTIC H-816 Would require insurance companies to pay for the services of chiropractors when that insurance company pays other practitioners for similar services. (Oppose)
H-817 An amendment to the "Chiropractic Practice Act" that would permit the Board to promulgate and enforce rules of "professional conduct appropriate to establish and maintain a high standard of integrity and dignity in the profession of chiropractic." (Oppose)
H-818 Would amend the so-called "Statutory Construction Act" suggesting that the word "physician" include "doctors of chiropractic." (Oppose)
DRUGS H-850 "Pennsylvania Drug, Narcotic and Alcohol Abuse Control Act of 1971" (Support)
H-851 "Drug, Device and Cosmetic Act of 1971" (Support with proposed amendments)
H-543 Would amend "The Drug, Device and Cosmetic Act" of 1961, further providing for records of distribution of dangerous and narcotic drugs. (Oppose)
H-923 Would amend the "Pharmacy Act" of 1961, further regulating the filling and refilling of prescriptions. (Oppose)
EYEGLASSES H-434 Would set standards for eyeglasses, sunglasses and frames sold to the general public-- they may not be inflammatory, etc. (Support)
FLUORIDATION S-716 Would require communities to fluoridate their public water supplies. (Support)
HOSPITALS S-427 Would set up a "Pennsylvania Hospital Control Commission" made up of three members appointed by the Governor of terms of six years. (Oppose)
H-600 "The Pennsylvania Health Agency Act" - Would set up a "Pennsylvania Health Agency" to control "Hospitals," "Health Services," "Health Professions," etc. (Oppose)
H-931 Would abolish state general hospitals as such, and provide for the communities to take them over. (Support)
HYPNOTISM S-638 Would create a board to license hypnotists and regulate those practicing hypnotism. (Oppose)

LIABILITY S-265 Would relieve physicians, hospitals and their employees from ordinary liability in certain cases involving emergency treatment procedures in operations to minors. (Support)
S-447 Would exempt physicians and nurses from ordinary liability whe participating in mass immunization projects approved by the Pennsylvania Department of Health. (Support)
S-528 Would amend the "Disease Prevention and Control Law" of 1955 t provide that any person under twenty-one may be treated for venereal disease by a physician without the consent of the minor's parents for which the "physician shall not be sued or held liable for properly administering appropriate treatment to the minor." (Support)
MEDICAL EXAMINER H-716 Would abolish all offices of Coroner in the state and authorize Department of Health to divide the Commonwealth i to regions for the purpose of establishing regional centers and medic examiners in those regions. (Support)
S-751 An Act relating to optional plans of government for Pennsylvan municipalities. (Support if medical examiners offices can be provided
MENTAL HEALTH S-636 Would give certain rights of treatment to mental patients in mental institutions, and set up hearing mechanisms and remedies for patients in mental institutions. (No formal action taken
H-720 "Rights of Mental Patients in State Institutions" (No formal action taken)
H-721 "Elimination of Peonage in Mental Institutions" (No formal act taken)
NURSING H-967 Would change the make-up and increase the size of the State Board of Nursing. (Support)
H-968 Would change certain definitions and the scope of the State Board of Nursing. (Support, except the nurses should eliminate the li censing concept for para-nursing disciplines)
OSTEOPATHY H-442 Would amend the "Medical Practice Act" to permit osteopaths to apply for examination and license. (Oppose)
H-443 Would amend the "Osteopathic Practice Act" to permit doctors o medicine to apply for examination and license. (Oppose)
PHYSICIANS' ASSISTANTS H-414 An amendment to the Medical Practice Ac to permit the Board of Medical Education and Licensure to regulate th training of "physicians' assistants." (Oppose)
SAFETY GLASS IN DOORS H-432 Would require the use of safety glazing materials in hazardous locations in residential, commercial and publi buildings. (Support)
S-29 Would require the use of safety glazing materials in hazardous locations in residential, commercial and public buildings. (Support)
TB TESTING H-433 Would amend the "Public School Code of 1949" reque ing tuberculosis tests for teachers, school employees and certain oth persons. (Support)
WELFARE MEDICAL PROGRAMS H-794 Defines "levels of care" in nursing homes, homes for the aged and infirm, and in boarding homes. The me ure puts back into the Department of Public Welfare some of the "musc needed to enforce regulations for boarding facilities. (Under study-d fer action until further advice from the Nursing Home Association)
H-795 Would amend the Welfare Code to give the Auditor General a li more authority in certifying to the cost of nursing home care. (Unde study-defer action until further advice from the Nursing Home Associ
H-806 Would make the Auditor General responsible for other payments der the medical assistance programs, including post-hospital home ca home health care and also authorize the department to pay for care f medical assistance recipients at a "public health center." (Support the deletion of the word chiropractor)

PMS president-elect appoints council members

George P. Rosemond, M.D., Philadelphia, president-elect of the Pennsylvania Medical Society, has announced his appointments to Councils for the 1971-72 Society year. They were confirmed at the May meeting of the Board of Trustees.

Council on Education and Science

James A. Collins, Jr., M.D., CHAIRMAN (Montour)
Jerome Chamovitz, M.D., VICE CHAIRMAN (Allegheny)
J. Reed Babcock, M.D. (Centre)
William F. Bouzarth, M.D. (Philadelphia)
William C. Grasley, M.D. (Centre)
John H. Killough, M.D. (Philadelphia)
Roland A. Loeb, M.D. (Lancaster)
Wilbert G. Lundgren, M.D. (Jefferson)
Frank M. Mateer, M.D. (Allegheny)
John H. Moyer, III, M.D. (Philadelphia)
Paul J. Poinsard, M.D. (Philadelphia)
Alexander Randall IV, M.D. (Montgomery)
James A. Raub, M.D. (Blair)
Joseph J. Schwerha, M.D. (Allegheny)
David M. Shearer, M.D. (York)
Bernard Sigel, M.D. (Philadelphia)
Nathan Sussman, M.D. (Dauphin)
Samuel G. Watterson, M.D. (Somerset)

Council on Governmental Relations

Edgar W. Meiser, M.D., CHAIRMAN (Lancaster)
Charles J. H. Kraft, M.D., VICE CHAIRMAN (Wyoming)
Leonard Bachman, M.D. (Philadelphia)
William C. Beck, M.D. (Bradford)
Robert J. Beitel, M.D. (Lehigh)
Robert J. Carroll, M.D. (Allegheny)
Anthony J. Cummings, M.D. (Lackawanna)
Donald E. Harrop, M.D. (Chester)
J. Preston Hoyle, M.D. (Union)
Philip E. Ingaglio, M.D. (Philadelphia)
Michael P. Levis, M.D. (Allegheny)
Fred J. Phillips, M.D. (Bucks)
James M. Smith, M.D. (Cumberland)

Council on Medical Service

D. Ernest Witt, M.D., CHAIRMAN (Columbia)
John Helwig, Jr., M.D., VICE CHAIRMAN (Philadelphia)
Allen H. Holt, M.D. (Mercer)
Robert H. Kough, M.D. (Montour)
Matthew Marshall, Jr., M.D. (Allegheny)
George R. Moffitt, Jr., M.D. (Dauphin)
William G. Ridgway, M.D. (Lancaster)
Robert A. Schein, M.D. (Allegheny)
Arthur H. Silvers, M.D. (Delaware)
Daniel S. Snow, M.D. (Erie)
John L. Steigerwalt, M.D. (Montgomery)
R. Robert Tyson, M.D. (Philadelphia)
Ralph M. Weaver, M.D. (Butler)

Council on Public Service

Kenneth L. Cooper, M.D., CHAIRMAN (Lycoming)
Robert N. Moyers, M.D., VICE CHAIRMAN (Crawford)
William F. Beyer, M.D. (Chester)
Stanley N. Cohen, M.D. (Philadelphia)
John C. Cwik, M.D. (Cambria)
H. Robert Davis, M.D. (Cumberland)
Leo C. Eddinger, M.D. (Lehigh)
Conrad A. Etzel, M.D. (Delaware)
Joseph T. Ichter, M.D. (Bucks)
Earle L. Keeter, M.D. (Schuylkill)
Paul H. Ripple, M.D. (Lancaster)
Ulysses E. Watson, M.D. (Montgomery)
Ralph C. Wilde, M.D. (Allegheny)

OVER THIRTY PHYSICIANS, county society executive secretaries, and members of the PMS staff journeyed to Washington recently to meet with Pennsylvania's Congressional Delegation. Most congressmen were available for interviews and attended a reception in their honor. In a follow-up meeting, delegates agreed that most of the congressmen do not expect a national health insurance program to pass this session of Congress. But most congressmen feel that the greatest need exists in the area of "catastrophic coverage" which can be added to existing legislation. Robert H. Craig, Jr., PMS director of governmental relations; Jerry L. Rothenberger, PaMPAC director; and members of the AMA staff briefed the delegation on the current status of national legislation at the meeting shown above.

Denenberg statement questioned by County Society

Action has been taken by the board of directors of the Philadelphia County Medical Society against the policy statement of Insurance Commissioner Herbert S. Denenberg, with regard to his statement concerning the salaries of hospital house officers.

Society President George Alan Hahn, M.D., has addressed a letter to Dr. Denenberg objecting to his position and has released the following resolution which was unanimously adopted at the Board of Directors meeting on June 2, 1971.

Whereas interns and residents render essential services to patients in hospitals, hospital emergency rooms and out patient facilities;

Whereas the medicare law provides specifically that costs of physicians in training must be charged as hospital costs ;

Whereas it has recently been proposed that the payment of house officers not be included in the hospital cost for purposes of Blue cross payments to hospitals, and;

Whereas commitments to individual house officers for the year 1971-72 have been made many months ago which could not be honored if such policy were now adopted;

The Board of Directors of the Philadelphia County Medical Society unanimously resolves that for the year 1971-72 it would be unwise and unfair to withdraw the salaries for house staff from hospital budgets and that these salaries must be a recognized component of the operating cost of the hospital to be used for the purpose of calculating reimbursement from Blue Cross, medicare and medicaid.

Be it also resolved that this issue be studied further by the Committee on Medical Economics and Board of Directors to develop the future policy of the Philadelphia County Medical Society.

Blue Cross of Philadelphia sued

The Hospital of the Medical College of Pennsylvania has filed suit in the Philadelphia Common Pleas Court in an effort to prevent Blue Cross from carrying out retroactive reductions in payments previously made under contracts beginning July 1, 1969, and July 1, 1970.

Marion Fay, PhD., acting president of the college, said that the litigation covers only reimbursements for costs already incurred by the hospital, claiming that Blue Cross has unilaterally imposed retroactive reductions in payments previously made without question.

Blue Cross has stated it will impose its decision by cutting payments to the hospital in coming months under its current contract. The hospital has taken the position that this is a violation of contract.

Tumor clinic elects officers

The annual meeting of the Wainwright Tumor Clinic Association was held at Polyclinic Hospital recently, with William Tyler Douglass, Jr., M.D., presiding. William C. Beck, M.D., Sayre, was installed as president and David D. Beiler, M.D., Danville, was elected president-elect.

Other officers chosen include Whitney C. Corsello, M.D., Pittsburgh; George R. Greenwood, M.D., Bethlehem; and Kenneth K. Meyer, M.D., Sayre. Drs. George A. Hahn, Philadelphia; Robert R. Carpenter, Pittsburgh; and Roland A. Loeb, Lancaster, were elected directors.

Flemming named chairman

Dr. Arthur S. Flemming, former secretary of Health, Education, and Welfare under President Eisenhower, has been appointed chairman of the White House Conference on Aging.

Blue Shield continues growth

Pennsylvania Blue Shield in 1970 marked its twelfth consecutive year of record-high subscriber enrollment, Allen W. Cowley, M.D., Harrisburg, chairman of the Board of Directors, reported to over 100 members of the Blue Shield Corporation at the group's annual meeting.

Membership exceeds 517 million persons. An additional two million are covered by government programs administered by Blue Shield, including medicare Part B, medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The plan serves nearly 65 percent of the population of the Commonwealth and is the largest Blue Shield plan in numbers of people covered.

Dr. Cowley reported other records set by the plan during 1970:

- The number of claims paid for subscribers of Blue Shield programs reached 3 million, up from 2.8 million in 1969.
- The number of claims paid for the three government programs totaled 2 million, an increase from about 1.8 million.
- The amount paid for subscribers' care under Blue Shield programs totaled nearly $131 million, up from $111 million in 1969.
- The amount paid under government programs administered by Blue Shield reached $99.5 million, an increase of more than $6 million.

Ragweed pollen count lower in 1970

Results of a ragweed pollen count conducted during 1970 by the State's Department of Environmental Resources reveal that the average index for the Commonwealth has dropped from a four-year average of 34 (1966-69) to a 1970 average of 30.

Ragweed pollen, admittedly the primary cause of hay fever, has been demonstrated to be controllable by (1) using selective herbicides and (2) physically cutting the plant just prior to the ragweed season in August.

PMS sponsors hospital law seminars

The Pennsylvania Medical Society will co-sponsor two series of seminars on hospital law with the Hospital Association of Pennsylvania and the American College of Hospital Administrators. Conducted by the Health Law Center in July and August, the seminars will be open to hospital administrators, medical staff members, attorneys, trustees, and nursing supervisors.

The first session, scheduled for July 12-14 at Holiday Inn, City Line Ave., Philadelphia, has as its subject hospital medical staff law (and bylaws). Included in the course objectives are: interpretation of the new Joint Commission of Accreditation of Hospitals (JCAH) standards and other changes in hospital law and policy; creation of legally acceptable administrative procedures in medical staff appointments, grants, modification, and revocation of privileges; and analyses of hospital and medical staff bylaws and administrative practices.

The second session, at the same location, will concern the law of emergency and outpatient services and will be conducted July 15-17. It will provide practical guidelines for dealing with the increasing responsibility of hospitals in relation to emergency and outpatient care practices. Among the subjects to be studied are: JCAH requirements, HEW and state regulations, statutory and case law, and changing community and governmental expectations. Participants will also learn to identify the standards of care by which the law now measures the adequacy of emergency and outpatient care practices.

The same seminars will be held in August at Hidden Valley, Somerset. Hospital medical staff law (and bylaws) will be given August 2-4 and the law of emergency and outpatient services on August 5-7.

John F. Horty, LL.B., and Eric W. Springer, LL.B., authors of *Hospital Law Manual* will serve as faculty for the conferences. Horty is president of Aspen Systems Corp. and director of the Health Law Center. Springer is also on the center's staff and is adjunct professor of health law at the Graduate School of Public Health, University of Pittsburgh.

Tuition at one session is $250. A tuition charge of $450 will cover both sessions for a registrant. Write Judy Protas, Registrar, Health Law Center Seminars, Webster Hall, Pittsburgh 15213, or telephone (412) 621-7192.

New health group to encompass five-county area

Group Health Planning of Greater Philadelphia, Inc. (GHP) a non-profit organization, has established itself as a five-county health corporation integrating existing facilities and personnel to attempt to lower medical costs through more efficient use of facilities and better distribution. H. Robert Cathcart of Pennsylvania Hospital, GHP chairman, stated "the key to the program is the amalgamation of hospitals, medical schools, unions, physicians' groups, insurers, employers, Blue Cross and Blue Shield into a consumer-oriented organization which can make better use of existing health resources."

By using existing insurance systems, planning costs and the accompanying time lag can be eliminated. Cathcart claimed "success depends on enlisting the skills and energies of a wide range of resources serving millions of persons in the area bordered by Trenton on one side and Wilmington on the other."

Current membership includes 20 hospitals, 4 physicians' groups, 8 insurers, 3 major unions, 7 consumer groups, 1 insurance company representing employers, and 9 health groups. All these groups have representation on the board of directors.

U.S. SURGEON GENERAL JESSE STEINFELD, M.D., center, recently delivered the annual W. Emory Burnett Honor Lecture sponsored by the department of surgery, Temple University Health Sciences Center. The lecture is named for the former chairman of surgery at Temple. Shown with Dr. Steinfeld at a dinner meeting are from the left: Drs. Paul Kotin, Temple vice-president in charge of health sciences; George P. Rosemond, professor and chairman of the department of surgery and PMS president-elect; Leroy E. Burney, former U.S. surgeon general and former Temple vice-president, who is now president of Milbank Memorial Fund; and N. Henry Moss, associate clinical professor of surgery and co-chairman of the dinner.

Hershey class chairman issues challenge

Editor's Note

Paul E. Pataky, M.D., Wyncote, chairman of the first medical graduating class at the Milton S. Hershey Medical Center of Pennsylvania State University, delivered the following meaningful remarks during the recent graduation ceremonies.

Dr. Pataky, who has accepted a rotating internship at Abington Memorial Hospital, prepared his remarks, typing them roughly on the back of an application form for an NIH trainingship, and delivered them exactly as he wrote them in the first draft.

As everyone here is undoubtedly aware, the building which stands on this site and the institution which it represents was established and constructed primarily through the endowment of the Hershey Trust, with additional grants from the federal government. While this in itself is an awesome accomplishment, perhaps few people here realize what a remarkable and unique situation it actually represents. Of the dozen medical schools which have been or are being created *de novo* in the past five years, this institution alone has been built primarily with private funds. The others have been developed with public funding. Indeed, our distinguished keynote speaker for today has served as dean and director of one such school, into which the citizens of Arizona have put a tremendous per capita financial commitment.

The establishment of our own state medical school by private endowment takes on even more significance when one realizes that it has been half a century since such an enormous infusion of money from a single source has been given to further medical education in this country. Millions of dollars were given by the Rockefeller and Carnagie Foundations at the close of World War I to establish full-time professorships at several medical schools. And indeed, the recipients of that beneficence today remain as the finest institutions of medical education in the country.

How fortunate, then, is the Commonwealth of Pennsylvania, already the home of six medical schools, to have seen the creation on the doorstep of its capital a medical school which is already acclaimed as a major innovative force in medical education, and which truly has the spirit and potential to be one of America's outstanding medical shcools.

A responsible committment by the Commonwealth to this institution can only return to the citizens of Pennsylvania a significant increase in the quality of health care, not just by continuing the medical school on its trend toward excellence, but through the expansion of training facilities to encompass nursing and other allied health fields, which are increasingly vital to the proper delivery of health care. If states with one-eighth the population of Pennsylvania can build a medical school from scratch, is it too much to expect our own state merely to share in improving its existing medical schools? I think not.

The Class of 1971 has seen this institution grow and improve steadily in the four years we have spent here. We are enthusiastic about its programs, and its promise. Our successors share this enthusiasm, confirming our belief that this institution is improving what needs reworking, and perpetuating what is already excellent. We know that the faculty, students and staff will continue to work on behalf of this school. It is the sincere desire of the Class of 1971 that the millions of Pennsylvanians whom this institution will benefit will do the same.

Twenty-fourth Annual State Dinner

Tuesday Evening
October 5, 1971
Pittsburgh Hilton Hotel
Reception Dinner
Dancing and Entertainment

- Installation of George P. Rosemond, M.D., as the 122nd President of the Pennsylvania Medical Society
- Presentation of Past President's Medallion to William A. Limberger, M.D., 121st President
- Presentation of State Benjamin Rush Awards

Seven Pennsylvania schools grant M.D. degrees

Hershey graduated its first class of medical students on June 5 when the Milton S. Hershey Medical Center of Pennsylvania State University was dedicated. M.D. degrees were received by 33 students and graduate degrees by four. The speaker at the combined exercises was Merlin K. DuVal, M.D., dean and director of the University of Arizona Medical Center, who has been nominated by President Nixon as assistant secretary of HEW for health and science affairs. Dr. Duval is a member of the board of governors of the American College of Surgeons.

University of Pittsburgh

The University of Pittsburgh School of Medicine graduated 96 seniors at their commencement exercises on May 27. Speaker for the occasion was Senator Hugh Scott.

Jefferson

Jefferson Medical College graduated 193 at its ceremonies on June 11 at the Academy of Music in Philadelphia. Governor Milton J. Shapp was the principal speaker.

Temple

Temple University School of Medicine reports that there were 9 women among the 134 graduates on May 27 at the City Line Avenue Holiday Inn. Speaker was John Kirkpatrick, M.D., professor of pediatrics and president of the medical school faculty senate.

Hahnemann

John M. Knowles, M.D., general director of the Massachusetts General Hospital in Boston, was speaker at the exercises at Hahnemann Medical College on June 10. M.D. degrees were conferred on 107 graduates, one of the largest classes in the history of the school.

MCP

The Medical College of Pennsylvania held commencement ceremonies May 26, graduating the last all-female M.D. class of 51 young women.

SHOWN ABOVE at the graduation of the first class of medical students at Hershey, George T. Harrell, M.D., dean of the medical school, addresses the audience. Shown below on the left, Larien E. Bieber, M.D., Brodbecks, York County, receives the first diploma from Dr. John W. Oswald, president of Pennsylvania State University. On the right, Paul E. Pataky, M.D., of Wyncote, chairman of the graduating class, delivers the remarks which appear on the opposite page.

Thomas C. Mendenhall, president of Smith College, delivered the main address and also received an honorary degree.

University of Pa.

On May 24 the University of Pennsylvania Hospital conferred M.D. degrees on 131 students.

One of the principal speakers in the 1971 series of institutes sponsored by the National Foundation of Health, Welfare, and Pension Plans is Russell B. Roth, M.D., of Erie. Speaker of the house of delegates of the American Medical Association, he discusses mass medical care in the 1970s with trustees and administrators who manage joint labor-management benefit plans.

Pennsylvanians included in nutrition survey

Some 1,500 Pennsylvanians currently are being invited to receive health and nutrition examinations as part of a nationwide survey conducted by the Health and Nutrition Examination Survey of the U.S. Public Health Service.

Locations to be visited in the Commonwealth include metropolitan Philadelphia, metropolitan Pittsburgh, and Mercer county.

Operationally, the survey is preceded in each area by interviewers from the Bureau of the Census, who visit the selected census tracts for the purpose of identifying the eligible persons and collecting related information. From this list of eligibles, a number of sample persons is selected and later contacted by health and nutrition examination representatives, who explain the survey, seek authorization for participation, and arrange appointments for the examination and transportation. No charge is made for the examination or transportation provided to and from the mobile examination center.

The survey will examine a representative sample of the U.S. population over the next two years, visiting sixty four locations throughout the country for this purpose. The survey will be collecting uniform statistical information on selected chronic disease conditions and on the nutritional status of the population aged 1 to 74 years. Persons to be examined are selected by scientific sampling techniques and invited to participate in the data-collecting process.

Each examination team consists of: a general examining physician, dermatologist, ophthalmologist, dentist, nurse, laboratory technician, two health technicians, secretary, three nutritionists, and supporting staff of administrative personnel.

All data and information collected from those individuals participating in the survey are used for statistical purposes only and are strictly confidential. A copy of examination findings, including laboratory findings (hemoglobin, red and white cell counts, cholesterol, iron, vitamin levels, etc.) may be made available to an examinee's personal physician or clinic physician should this be requested and authorized by the examinee. Findings of the examination are not made available to the examinee by the examining staff, but rather through his physician.

THE THIRD ANNUAL Teachers Conference on Continuing Education in Psychiatry held recently in Philadelphia brought together educators in this field from throughout Pennsylvania. In the above photograph, H. Keith Fischer, M.D., of Temple University, addresses the conference, and Paul J. Fink, M.D., also of Temple, looks on. Below, left to right, are Rex Pittenger, M.D., of the University of Pittsburgh; William C. Webb, M.D., University of Pennsylvania; and Benjamin Schneider, M.D., Danville, a member of the Pennsylvania Steering Committee.

Philadelphia State Hospital no longer crowded

Franklyn R. Clarke, M.D., superintendent at Philadelphia State Hospital, Byberry, has made known that for the first time in its 65-year history, overcrowding has ended. Dr. Clarke attributed the shrinking patient population to several factors:

1. Advances in psychiatry, including chemotherapy;
2. The increase of individualized treatment programs within Philadelphia State Hospital;
3. Improved admissions procedures;
4. More highly trained staff;
5. Better pre- and post-hospital care, facilitated by the growth of community mental health centers;
6. Greater public understanding;
7. The recognition that reduced hospital stays increase a patient's chance of returning home and resuming regular activities.

PMS rotogravure

THE GAVEL is received by the new president of the Pennsylvania Association of Medical Assistants, Mrs. Agnes E. Smith, of Luzerne County, from PMS Past President Lewis T. Buckman, M.D., Wilkes-Barre, the installing officer at the recent PAMA convention in Pittsburgh. Mrs. George F. Dolack of Dauphin County was chosen president-elect of the group.

JAMES Z. APPEL, M.D., top, of Lancaster, past president of the American Medical Association, and Allan W. Cowley, M.D., bottom, of Harrisburg, past president of the Pennsylvania Medical Society, have been named honorary members of the Pennsylvania Association of Medical Assistants (PAMA) for their help in the development of that organization. The action was taken by unanimous vote at the recent annual meeting of PAMA.

THE DAUPHIN COUNTY MEDICAL SOCIETY recently met at PMS Headquarters in a joint session with hospital staffs. Shown above from the left are John Worman, executive director of the Hospital Association of Pennsylvania; David A. Smith, M.D., medical editor of PENNSYLVANIA MEDICINE; Claude Nichols, M.D.; and Raymond C. Grandon, M.D., county society president and secretary of the State Society.

THE NEED for continuing medical education and the medical education foundation were topics explored during the recent PMS Officers' Conference. Shown above are some of the participants in this presentation. Left to right are Norman S. Stearns, M.D., director, Postgraduate Medical Institute, Boston, Mass.; Robert L. Evans, M.D., vice-president for medical affairs at York Hospital, who leaves this month for a new post in Illinois; John H. Boal, M.D., Beaver, member of the Officers' Conference Committee; and, at the rostrum, John H. Moyer, M.D., chairman of the department of medicine, Hahnemann Medical College. Proposed continuing education requirements for PMS membership are outlined elsewhere in this issue of PENNSYLVANIA MEDICINE.

PSU professor studies new ascorbic acid use

Dr. Ralph Mumma of Pennsylvania State University's School of Agrieulture, has presented a paper before the Federation of American Soeieties for Experimental Biology in Chicago deseribing the identificaion of a chemieal mechanism, triggered by ascorbic acid, that flushes cholestrol from the arteries and organs in an experiment on rats.

Dr. Mumma said, "A derivative of ascorbic acid vastly accelerated the excretion of cholesterol from our experimental animals. We don't know at the moment where the discharged cholesterol came from and that presents a major task for further experiments. But the present results raise the speculation— and it is only speeulation at the moment— that large doses of some form of ascorbic acid might one day be used to remit— or prevent— atherosclerosis in human beings."

Experiments with guinea pigs, rats, and rabbits given heavy doses of ascorbic aeid have responded with lowered cholesterol levels in the blood, inhibiting atherosclerosis. It appears that Dr. Mumma's experiment seems to identify the mechanism by which these favorable reactions occur. Apparently cholesterol discharge is accelerated by a biochemical reaction known as sulfation which enhances cholesterol's susceptibility to being dissolved by water. It makes cholesterol "flushable" and may even pry loose cholesterol already hardened on arterial walls. Experiments by Dr. Mumma in 1968 had previously demonstrated the capacity of ascorbic acid sulfate to act as a sulfating agent. The ability of natural ascorbic acid to trigger some sulfation having previously been established, present experiments are showing that an artificial derivative (L-Ascorbie Acid 3-Sulfate) can raise sulfation to relatively massive proportions.

Aided by Anthony Verlangieri, a graduate student in biochemistry, the scientists injected inorganic sulfate (no ascorbic acid) into one group of rats to determine a base-line of cholesterol sulfate excretion (0.11). Then they injected ordinary inorganic sulfate plus ascorbic aeid into a second group. Cholesterol sulfate discharge (through the feces) doubled. (0.21). Further injecting ascorbic acid that had already been sulfated into a third group, the cholesterol discharge rate jumped by a factor of fifty (6.05).

Dr. Mumma theorized, "Ascorbic acid alone evidently encourages the sulfation and ultimate excretion of cholesterol. But ascorbic acid that has been pre-sulfated, prior to injection, dramatically increases the entire sulfation process and we have pinpointed the effects upon cholesterol... These results suggest that, ultimately, an ascorbic acid sulfate might be taken in large doses by human beings to help the body metabolize and get rid of excessive cholesterol in the blood."

Dr. Mumma's conclusions are cautious: "Much more needs to be done before ascorbic acid can be certified as an anti-cholesterol agent for human beings. At the moment, not even Dr. Pauling knows precisely how ascorbic acid works as a vitamin. Optimum dosages remain to be determined. And side-effects must be scrupulously examined... We would not want to accelerate cholesterol excretion at the possible jeopardy of some other bodily functions. Ascorbic acid sulfate, administered as a drug, would have to be respected as a drug— with all the caution that implies."

Drug abuse training at pharmacy college

The Philadelphia College of Pharmaey and Science has received approval from the U.S. Public Health Service for a training program titled "Drug Abuse Education for Health Professionals."

Designed for pharmacists, physicians, and other health personnel, it will deal with factors predisposing to drug abuse, the pharmacology and toxicology of drugs which are abused, the legal aspects of drug abuse, treatment and rehabilitation programs, and drug abuse prevention programs.

Tuition will be free to qualified applicants, but enrollment is limited to 100. Application forms may be obtained from the director, Dr. Allen M. Kratz, Philadelphia College of Pharmacy and Science, Forty-third St. and Kingsessing Ave., Philadelphia 19104.

The course is scheduled each Wednesday, 6:30 to 9:30 p.m., beginning September 8, 1971, and will last for six weeks.

SVRMP receives grant award

The Susquehanna Valley Regional Medical Program (SVRMP) has received a grant award of $625,710 from the U.S. Department of Health, Education, and Welfare to run through March 31, 1972. The announcement was made by Ellsworth R. Browneller, M.D., Danville, chairman of the Regional Advisory Group.

This is representative of a nationwide 12 percent budget cut for the program which has necessitated a reduction of the staff of SVRMP to twenty people.

Despite this, the number of projects has been increased. Current projects include: the Columbia-Montour Home Health Services, Inc., Bloomsburg, servicing Columbia and Montour counties; the Geisinger Medical Center radiological health and coronary care training programs; a coronary care training program fo nurses at the Altoona Hospital; an en terostomal therapy training program a Harrisburg Hospital; and the SVRM informational service at the library c Milton S. Hershey Medical Center c Pennsylvania State University, whic is supported financially by the Penn sylvania Medical Society.

Correction

The April 1971 issue of PENNSYL VANIA MEDICINE carried an origin scientific paper entitled "Treatment Parkinsonism with Amantadine H drochloride." The complete names the authors, because of a technic error in the printing process, did n appear. Co-authors of the paper a Jack Greenburg, M.D., Philadelphi and Burton Diamond, M.D., Lo Island, N.Y.

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transition.

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The road to normalized thyroid status is a continuous one. You make it smooth and economical with SYNTHROID.

1. The deiodination of T_4 to T_3 at the cellular level has been discussed in the literature. Reprints on the subject are available from the Flint Laboratories Medical Department. Use of T_4 alone therefore provides your patients with a natural hormone combination of T_3—T_4.
2. Patient cost of SYNTHROID is less than a penny a day more than desiccated thyroid. SYNTHROID costs patients nearly 50% *less* than the synthetic combination products: American Druggist BLUEBOOK, March 1970-71

Synthroid®
(sodium levothyroxine)

FREE
MEDICATION DISPENSERS
TO START ALL YOUR PATIENTS ON SYNTHROID, IN THESE STRENGTHS:
0.05 mg. (white); 0.1 mg. (yellow); 0.15 mg. (violet); 0.2 mg. (pink).

seven color-coded strengths plus injectable

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **Injection** is indicated in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. When a patient does not respond to oral therapy, SYNTHROID (sodium levothyroxine) injection may be administered intravenously to avoid any question of poor absorption by either the oral or the intramuscular route.
Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmond's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.
Contraindications: Thyrotoxicosis, acute myocardial infarction.
Side effects: The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.
Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).
Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100 and 500. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) INJECTION may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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DIVISION OF TRAVENOL LABORATORIES, INC.
Morton Grove, Illinois 60053

As your hypothyroid patients travel along the smooth road, let us be of service in these 4 specific ways:

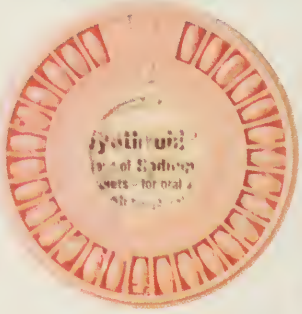
1 FREE FILM AND BOOK ON HYPOTHYROIDISM: In a 30-minute, 16-mm. sound/color film, 5 prominent endocrinologists discuss "Thyroid Deficiency—Current Concepts of Diagnosis and Treatment". Film available on FREE loan to physician groups or hospitals.

A new book, soon to be published, is devoted to the clinical aspects of hypothyroidism. The author, a leading endocrinologist, describes the many faces of the condition and emphasizes the importance of clinical assessment of the patient. Write, or ask your Flint man, to be placed on our list to receive a free copy.

2 NEW THYROID FUNCTION TEST BOOK: Newly published *Guideposts to Thyroid Therapy* discusses the tests most appropriate for use with each type of thyroid medication. Fully describes thyroid function tests and places their relative values in perspective for physicians. It will give you valuable new insights into the role of these tests in diagnosis and treatment. FREE—ask your Flint man.

3 TO START THERAPY, FREE TAB-MINDER dispensing units, color-coded to match colors of SYNTHROID tablets in starting dosage strengths. TAB-MINDER helps patients to regularly take the thyroid dosage you prescribe, avoid medication errors. Ask your Flint man.

FREE
MEDICATION DISPENSERS
TO START ALL YOUR PATIENTS ON SYNTHROID, IN THESE STRENGTHS:
0.05 mg. (white); 0.1 mg. (yellow); 0.15 mg. (violet); 0.2 mg. (pink).



4 SYNTHROID® INJECTION FOR THYROID EMERGENCIES: Whenever (as in myxedema coma) rapid replacement of thyroid hormone is needed to sustain life, prompt clinical response is essential. SYNTHROID INJECTION makes this therapy instantly available. Useful also in postoperative thyroid medication situations until oral therapy can be reinstated. Ask your Flint man for further information.

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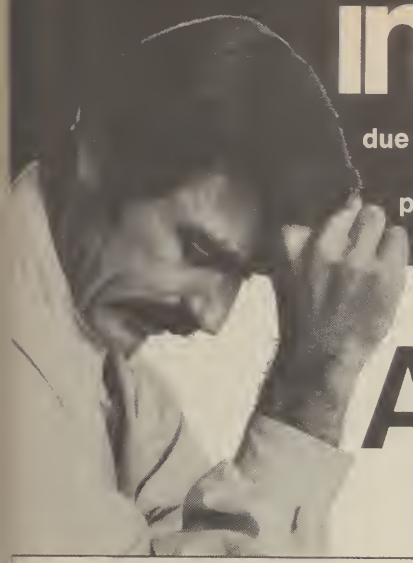
The treatment of

impotence

due to androgenic deficiency in the American male. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients—Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



Android®

(thyroid-androgen) tablets

Double-Blind Study and Type of Patient:

100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

REFER TO PDR

Android-HP

HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Montesano, P., and Evangelista, I. Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Titeff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

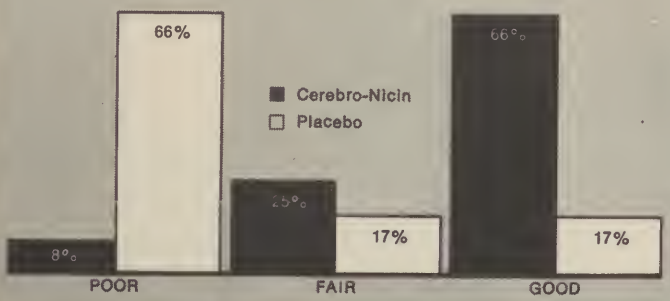
Write for literature and samples: BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West 6th Street, Los Angeles, California 90057

For the treatment of the aging patient

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl., of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir 8 oz. bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

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BROWN **THE BROWN PHARMACEUTICAL CO.**
2500 W. 6th St., Los Angeles, Calif. 90057
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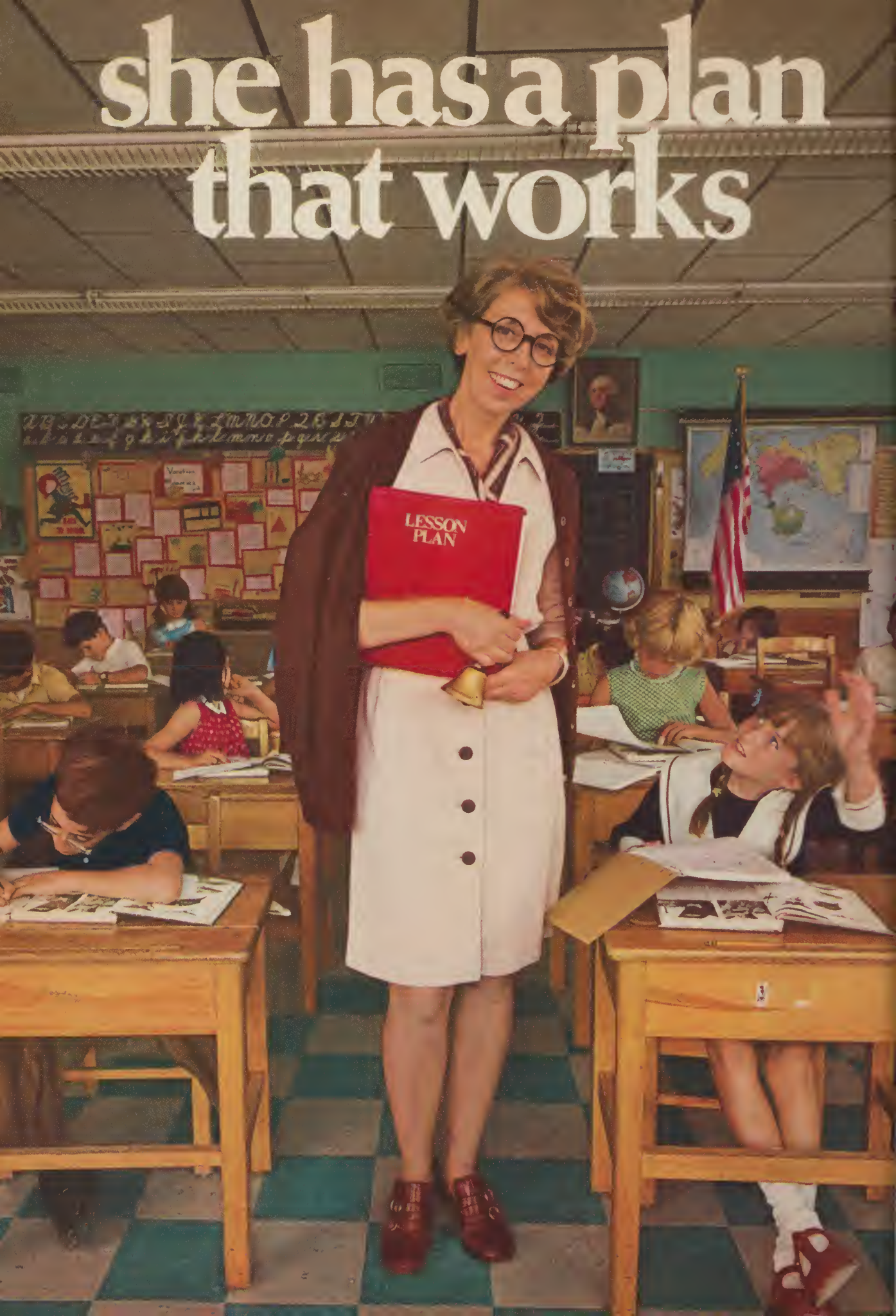
she has a plan that works



She has a plan that works.

She has one plan for the class. And they really respond.

She has another plan just for herself. A medication plan for her hypertension. And she's also responding beautifully.

More than just another antihypertensive, Ser-Ap-Es can be a whole medication plan for living with hypertension.

Does it get good marks for comfort?

Excellent. Because Ser-Ap-Es controls blood pressure effectively, dosage of each component is lower than if prescribed alone, usually minimizing side effects. However, side effects may occur (see prescribing information).

Designed with the kidney in mind?

Hydralazine maintains or increases renal blood flow.

And the brain too?

Hydralazine also relaxes cerebral vascular tone. And reserpine has beneficial calming action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

Practical on a teacher's salary?

Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits…

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

C I B A

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

a plan for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

INDICATIONS: All cases of hypertension except the mildest and the most severe.

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

Hydralazine: Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Reserpine: The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydralazine: Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

Hydralazine: Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Reserpine: Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

Hydralazine: Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE: One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

SUPPLIED: *Tablets* (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

she has a plan that works for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

CIBA

DISCUSSING the family practice residency program at York Hospital, and the role played by York College are, left to right, Peter Kenedy, M.D.; Eugene Mlynarczyk, M.D.; Elizabeth Wilson, M.D. (standing); Thomas M. Hart, M.D., director of the clinic; William Lynn, M.D. (standing); Robert Schmidt, PhD. and William Ashbaugh, PhD., of York College; and James Wilson, M.D.

York Scene of Family Practice Residency Experiment

JEROME DYER

Associate Director
of College Relations
York College

A joint venture in medical education, possibly unique in the nation, is under way in York, Pennsylvania.

York College, a private, liberal arts institution and York Hospital, a private, community hospital, are coordinating an extensive training program for York Hospital family practice resident physicians enrolled in the York Family Practice Center.

According to the director of the Family Practice Center, Thomas M. Hart, M.D., this joint venture is the only such project between two independent institutions. Other family practice programs are operated within university medical schools and hospitals. It was felt that for the best involvement of young physicians with the total community, two such institutions as York College and York Hospital were ideally suited.

The concept of family practice, as interpreted in York, is of a specialty equal to other medical specialities, but involving more areas of expert knowledge.

The old fashioned concept of the "family doctor" suggests the scope of family practice. He had to be a bit of everything to every man. He was a philosopher, psychologist, psychiatrist, social worker, businessman, financier, civic community leader, auto mechanic and file clerk as well as a total general practitioner.

"In truth," Dr. Hart points out, "family practice must be nothing less than the total, comprehensive, continuing care of the family as a unit."

This concept entails much non-clinical knowledge on the part of the practitioner since the family unit is not a purely medical organism. It is made up of many separate entities totally independent yet interrelated.

The nature of this relationship is the object not so much of medical study as of those disciplines best examined within an academic atmosphere.

Dr. Hart has turned to York College as a source of such informational and instructional capabilities.

A joint effort coordinated by the College Continuing Education Office has created a curriculum including the fields of psychology, sociology, law, business administration, finance and computer science.

Resident physicians enrolled at the Family Practice Center attend a series of seminars at which they are exposed to the entire range of disciplines necessary if they are to attempt treating the family "as a unit."

Under the direction of Dr. Robert Schmidt, chairman of the Department of Behavioral Sciences, the young physicians learn the techniques of psy-

chological testing and measuring. Learning theories and the methods of psycho-therapy are investigated. They discuss care for the neurotic through the principles of learning. "Bedside Manner" (or as it is more properly termed, "Positive Reinforcing Experience") is practiced.

Dr. Schmidt also lectures on the psychological development of the child within the family and problems ranging from sibling rivalry, divorce and broken homes to bedwetting and security blankets.

Dr. William Ashbaugh, psychologist on the York College faculty, created a curriculum which integrates the abstractions of psychology and the concrete realities of business. His seminar sessions introduce the physicians to the sociological pressures under which a family unit functions and describes the effects these pressures can be expected to exert upon a family practice.

He also leads the doctors in discussions of how sociological factors are instrumental in all other activities of a family practitioner. These include the socio-economic positions of families within a community, racial tensions, sex education and the changing moral and social climate as well as the ubiquitous financial strains within a family budget.

Even the wives of the doctors attend at least one seminar session since the doctor's family itself influences, for better or for worse, his ability to function effectively.

Dr. Ashbaugh tapes these "encounter sessions" and they are played back to detect the subtle strains and incompatibilities which, if left undetected and misunderstood, could become decisive.

The sociological aspects serve to bridge the gap between psychology and business. It is from such diverse pursuits, however, that an effective family physician must fashion his life style.

Colonel P. Frank Lisk, chairman of the Business Administration department at York College, developed his seminars based on this requirement of practicability.

These programs confront the physicians with the "nuts and bolts" of efficient operation of a family practice office, and teach them how to put them together.

They include business organization, management, accounting, secretarial methods, taxes, law, record keeping, medicare requirements and insurance.

The director of the York College computer center, Mr. George Beahan, instructs the doctors in the intricacies of utilizing the computer and its data processing function, in assisting in cases ranging from diagnosis to the family budget.

The program was designed specifically for its exclusive enrollment and is integrated with the training received at York Hospital. In addition the students serve as assistants in the offices of various specialists, and in industrial dispensaries. They observe activities at domestic relations court and study operations of various civic, governmental and service organizations.

President Ray A. Miller of York College says in describing the program, "medical specialists treat specific bodily problems; family practice specialists treat the family. A family is made up of people, and people are the specialty of York College."

m.d.'s in the news

A speech on the subject of "Frontal Sinus Surgery" was presented by **Donald P. Vrabec, M.D.**, of the department of otolaryngology, Geisinger Medical Center, at the Mayo Otolaryngology Alumni Clinical Conference.

Peter Randall, M.D., surgeon at the Children's Hospital, Philadelphia, presented three papers recently. At the American Cleft Palate Association meeting in Pittsburgh he spoke on a simplified system for recording and recovering information in a cleft palate clinic and on complications following posterior pharyngeal flaps. He spoke before the Plastic Surgery Research Council in Rochester, Minn. on soundspectrographic anaylsis of speech in patients with cleft palate.

William Y. Rial, M.D., of Swarthmore, speaker of the PMS House of Delegates, has been elected vice-chairman of the Section Council on Family and General Practice. **Edward J. Kowalewski, M.D.**, Akron, past president of the American Academy of General Practice, was elected alternate delegate from the same section council.

Newton Hornick, M.D., Pittsburgh, senior radiologist at Suburban General Hospital, has been elected a member of the board of chancellors of the American College of Radiology. Dr. Hornick, who is also attending radiologist at Dixmont State Hospital, is past president of the Pittsburgh Roentgen Society and president of the Pennsylvania Radiological Society.

DR. HORNICK

DR. LEWIS

Earl T. Lewis, M.D., has been named director of the Medical Communications Division of Wyeth Laboratory's newly-created medical affairs department. The announcement was made by **Daniel L. Shaw, Jr., M.D.,** vice-president of medical affairs.

Schuylkill County honored eight doctors by presenting them with plaques for 50 years of medical service. They are **Drs. Russell Sweeney**, Allentown, **William J. O'Neill**, Ashland, **M.O. Blechschmitt**, Cresona, **Guy Bashore**, Minersville, **William Leach**, Shenandoah, **Walter Luchinsky**, Mahanoy City, **William Dorasavage**, Pottsville, and **William Cress**, Pottsville.

A number of state physicians have been honored by receiving fellowships in the national organizations of their specialties. **Robert R. Conte, M.D.**, Latrobe, was installed as a fellow of the American College of Obstetricians and Gynecologists. **S.C. Carfagno, M.D.**, Norristown, has been granted a fellowship in the American College of Cardiology. **Richard Russel** of Harrisburg has been similarly honored by the American College of Cardiology.

Karl Peterson, M.D., Wyalusing, has been uniquely honored at a testimonial dinner in recognition of his services to his Bradford County community as a "dedicated family doctor." Dr. Peterson, who graduated from the University of Pittsburgh Medical School in 1956, has introduced more than 1300 babies into the world.

Frederick Murtagh, M.D., Philadelphia, has been appointed chairman of the department of neurosurgery at Temple School of Medicine. He was former chairman of the medical school division of neurological and sensory sciences.

Francis O. Lamb, M.D., has been appointed assistant superintendent at Dixmont State Hospital and chief of the Beaver Unit. He is a diplomate of the American Board of Psychiatry and Neurology, and the National Board of Medical Examiners.

The medical director of Friends Hospital, Philadelphia, **Ulysses E. Watson, M.D.,** has been named to the hospital improvement program committee of the National Institute of Mental Health for a four-year term. He is a member of both the Pennsylvania and Philadelphia Psychiatric Societies. His duties will include reviewing applications for hospital improvement grants to state mental hospitals.

DR. WALLACH

DR. ISRAEL

S. Leon Israel, M.D., Philadelphia, has retired as director of obstetrics and gynecology at Pennsylvania Hospital. He will be succeeded by **Edward Eliot Wallach, M.D.**, effective July 1.

Dr. Israel has been a professor of obstetrics and gynecology at the University of Pennsylvania Hospital for the past sixteen years and director since 1962. From 1961-68 he served as a director of the American Board of Obstetrics and Gynecology. He is president-elect of the American Gynecological Society.

Dr. Wallach has been chief of the endocrinology section in the department of obstetrics and gynecology since 1968. He is a diplomate of the American Board of Obstetrics and Gynecology, a fellow of the American Fertility Society, and of the American College of Obstetrics and Gynecology.

The Philadelphia Medical Society announced the Strittmatter Award was presented to **Joseph Stokes, Jr., M.D.,** of Philadelphia. This award was established in 1923 by I.P. Strittmatter, M.D., then president of the society, to be given each year "to a physician for extraordinary meritorius service redounding to the credit of the medical profession."

Richard J. Hildebrandt, M.D., has been appointed associate professor of obstetrics and gynecology at Pennsylvania State University Medical Center, Hershey. He is a member of the Society for Gynecologic Investigations.

The Lackawanna County Medical Society honored two of its members, **Carl L. Hosier, M.D.,** and **Cecil R. Park, M.D.,** both of Scranton, for fifty years of service to their profession.

Richard W. Hanson, M.D., and **F.J. Ballard, M.D.**, associate professors of biochemistry at Temple School of Medicine and investigators at Fels Research Institute, are among three scientists sharing the American Institute of Nutrition's Mead Johnson Award for their work in the metabolism of lipid substances.

Peter H. Berman, M.D., neurologist at Children's Hospital at Philadelphia, received a grant from the United Cerebral Palsy Association which will enable Children's to offer a clinical fellowship to promote training in the neurological aspects of cerebral palsy.

Raul Fleischmajer, M.D., and **Alan H. Schragger, M.D.**, both of the dermatology division in Hahnemann's department of medicine, developed an exhibit called "Familial Hyperlipoproteinemias." The exhibit was prepared for the annual meeting of the American Medical Association

DR. FISHER

Bernard Fisher, M.D., professor of surgery at the University of Pittsburgh School of Medicine, was the keynote speaker at the International Symposium on metastases in San Remo, Italy.

Authorities in the field of tumor metastases from Sweden, England, France, Italy, and the United States participated in the symposium, which was sponsored by the Carlo Erbe Foundation of Milan. Representing the United States in addition to Dr. Fisher, was Dr. Charles Huggins, nobel laureate and member of the Ben Ma Laboratory for Cancer Research of the University of Chicago.

WILLIAM F. KELLOW, M.D., dean of Jefferson Medical College, left, standing with Gonzalo E. Aponte, M.D., and his wife in front of a painting of Dr. Aponte, professor and chairman of the department of pathology. The senior class of Jefferson selected Dr. Aponte to receive the honor of having his portrait included in McClellan Hall, the highest personal honor a faculty member can achieve.

Lewis D. Polk, M.D., Philadelphia, deputy health commissioner for the health department's community health service, has been elected vice-president of the Pennsylvania Public Health Association, Region I. The association is composed of physicians, dentists, engineers, sanitarians, health educators and nurses.

The U.S. Food and Drug Administration's consultant group on the use and testing of antiobesity drugs has added a new member, **Marcus M. Reidenberg, M.D.,** Philadelphia. He is an assistant professor of pharmacology and medicine at Temple University School of Medicine.

A hospital appointment of interest is that of **Dan W. Elliott, M.D.,** to the position of professor of surgery at the University of Pittsburgh School of Medicine. Specializing in gastroenterology, Dr. Elliott has been chief of surgery at the Western Pennsylvania Hospital in Pittsburgh since 1965. He is an editor of the *American Journal of Surgery* and the *American Surgeon*.

The Philadelphia Allergy Society has announced the election of **Burton Zweiman, M.D.** as president, **Peter E. Siegler, M.D.,** vice-president, and **George R. Green, M.D.,** secretary-treasurer for the society.

The new medical library at Paoli Memorial Hospital has been dedicated to the memory of **Robert Merritt White, M.D.**, chief of staff at the hospital until the time of his death in 1969. His son, **Jack White, M.D.**, present chief of surgery, spoke at the dedication ceremonies. **Horace F. Darlington, M.D.**, and **Herbert Faust, M.D.**, chairman of the library committee, also participated.

From the American College of Allergists comes news of **Mayer A. Green, M.D.,** Pittsburgh, who assisted in examining applicants for fellowship in the college at the annual congress recently held in San Francisco, Cal. He served on a panel discussion on emotions and bronchial asthma at the college congress. At a post-convention, postgraduate course in allergy at the University of Hawaii School of Medicine in Honolulu, Dr. Green presented a paper on urticaria and angioedema and chaired a panel on asthma and status asthmaticus.

Richard H. Michaels, M.D., acting chairman of the Pittsburgh Physicians for Social Responsibility, spoke at a rally on the steps of Scaife Hall, University of Pittsburgh, to gather signatures of persons supporting immediate withdrawal of American troops from Vietnam. **Robert G. Tyson, M.D.,** spokesman for the group, said that 310 signatures were obtained at the rally. He added that 55 physicians are members of the anti-war group.

A Berwick physician, **James B Gormley, M.D.,** has been credited by *Medical World News* for preliminary work done nine or ten years ago which formed the basis for a technique now being done by two Air Force anesthesiologists for preventing the headaches that sometimes follow a spinal tap. Dr Gormley is now testing another use for the injection of autologous blood as a "patch" in connection with spinal anesthetics which have a tendency to drain out during an operation. By applying epidural blood to seal them, Dr Gormley has found that the effectiveness of the anesthetic can be lengthened from the normal hour or two up to six hours.

The 1971 Humanitarian Award of the Philadelphia Society of Clinical Psychologists went to **Charles S. Cameron, M.D.**, president of Hahnemann Medical College and Hospital, Philadelphia. Under Dr. Cameron's leadership, a new community child mental health and mental retardation program has been developed with a strong emphasis on research. Dr. Cameron is a past president and member of the board of American Cancer Society, Philadelphia Division; a scientific advisor to the Papanicolaou Cancer Research Institute, Miami, Florida; forming member of the International Society of Cytology; and founder and past consulting editor of CA, a bulletin of cancer progress.

C. Everett Koop, M.D., surgeon-in-chief at the Children's Hospital of Philadelphia and professor of pediatric surgery at the University of Pennsylvania School of Medicine, delivered a lecture at the Clinical Infantil "La Paz," Madrid, Spain, on advances in pediatric surgery and one on neuroblastomas at the University of Marsielle, Marsielle, France. He also attended a meeting of the British Association of Pediatric Surgeons in Genoa, Italy.

Milo J. Lota, M.D., chief of physical medicine and rehabilitation service at the Lebanon VA Hospital, has published a paper on the use of ultrasonic echography in studying peripheral vessels. Based on the sonar principle first used in submarine detection, this principle has been adapted for medical use to locate arteries and veins and measure their dimensions. One of its important applications will be the early detection of cerebral vascular pathology, hopefully leading to prevention of strokes.

Ki-Yong Sohn, M.D., University of Pittsburgh, has been awarded a research grant from the Leukemia Society of America Inc. This is part of $1,190,019 total grants announced by **Joseph H. Burchenal, M.D.,** vice-president and chairman of the agency's medical and scientific advisory committee.

Another honor has been bestowed on **M.R. Hadley, M.D.**, who won the Pennsylvania's Physician of the Year Award in 1969 and the Jewish War Veterans Brotherhood Award. This time it is a presidential citation given by Rep. Joseph M. Gaydos at McKeesport Hospital's annual dinner-dance. Dr. Hadley has retired after 42 years of service, but will continue to serve his community as a member of the board of trustees of the hospital.

AT HAHNEMANN, shown above, left to right, at the dedication of the new cardiac intensive care unit are: Theodore Cooper, M.D., director, National Heart and Lung Institute, watches as Charles S. Cameron, M.D., president, Hahnemann Medical College and Hospital of Philadelphia, passes the keys to the new Mary Bailey Institute Cardiac Intensive Care Center to William Likoff, M.D., clinical professor of medicine (cardiology) and director, Cardiovascular Research Institute, and Leonard S. Dreifus, M.D., acting director, Division of Cardiology. The new center, containing 19 beds, cost some $600,000 to construct and contains the A.P. Orleans Acute Care Unit, the Mary and Manuel A. Frank Cardiac Catheterization Laboratory and the Slocum-Dietrich Continuing Care Unit.

David W. Kistler, M.D., Wilkes-Barre, has been installed as president of the Pennsylvania Academy of General Practice. **J. Scott Hommer, Jr.**, Altoona, has been named president-elect. A professor of obstretrics and gynecologist at the University of Pittsburgh, **T. Terry Hayashi, M.D.**, has been selected as president of the Society for Gynecologic Investigation. He was also named as a fellow in the American Gynecological Society.

The new section councils of AMA have elected several Pennsylvanians to serve. **Charles L. Leedham, M.D.**, Harrisburg, will be a delegate to the Council on Military Medicine, while **Charles M. Norris, M.D.**, and **John A. Tucker, M.D.**, both of Philadelphia, will serve as vice-chairman and representative for exhibits, respectively, on the Council of Otorhinolaryngology.

Cedric E. Dunn, M.D., New Brighton, has received the Geneva College Alumni Association's award of merit.

The seventh annual scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery, Inc. heard papers presented by four Pennsylvania physicians. **Gordon P. Holt, M.D.,** and **James W. Schweiger, D.D.S.,** both of Philadelphia, delivered results of a study entitled "Criteria for Predicting Velopharyngeal Closure in the Unrepaired Cleft Palate Patient." Dr. Holt is assistant professor of otolaryngology at Jefferson Medical Center, and Dr. Schweiger is professor and head of dentistry at Jefferson Medical Center and Thomas Jefferson University. **Eugene N. Myers, M.D.,** professor of clinical otolaryngology at the University of Pennsylvania School of Medicine, presented a paper entitled "Reconstruction of the Pharynx Following Major Complications of Surgery for Neoplasms." The paper of Pittsburgh otolaryngologist, **Kenneth H. Hinderer, M.D.,** clinical associate professor at the University of Pittsburgh Medical School, is entitled "The Effects of Air Currents on the Naso-Respiratory Mucosa." Dr. Hinderer, president of the International Rhinologic Society, is the author of a new text, *The Fundamentals of Anatomy and Surgery of the Nose.*

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In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[1-4] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[2,4] and observation of clinical improvement.[1,3]
Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODILAN tablets, isoxsuprine HCl 10 mg. and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories. References: 1. Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. 2. Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. 3. Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. 4. Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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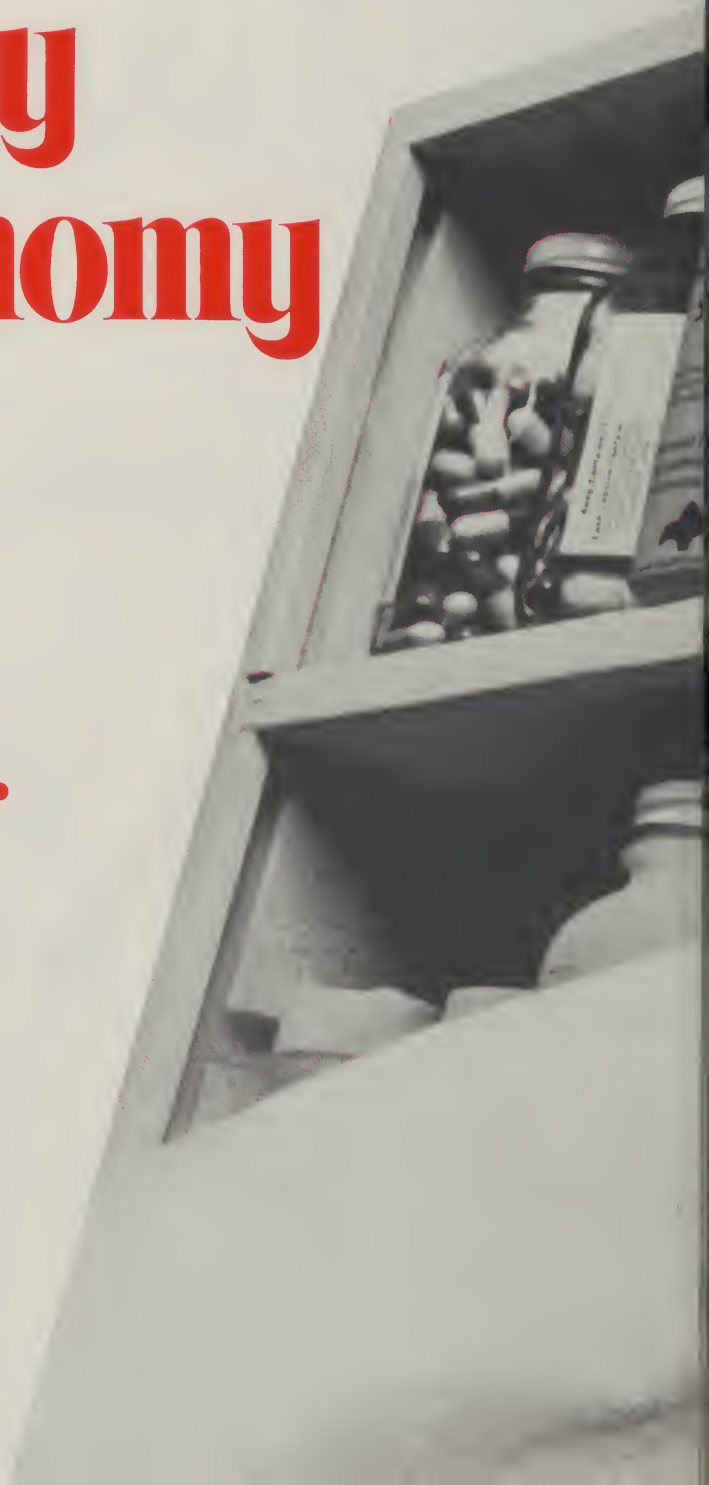

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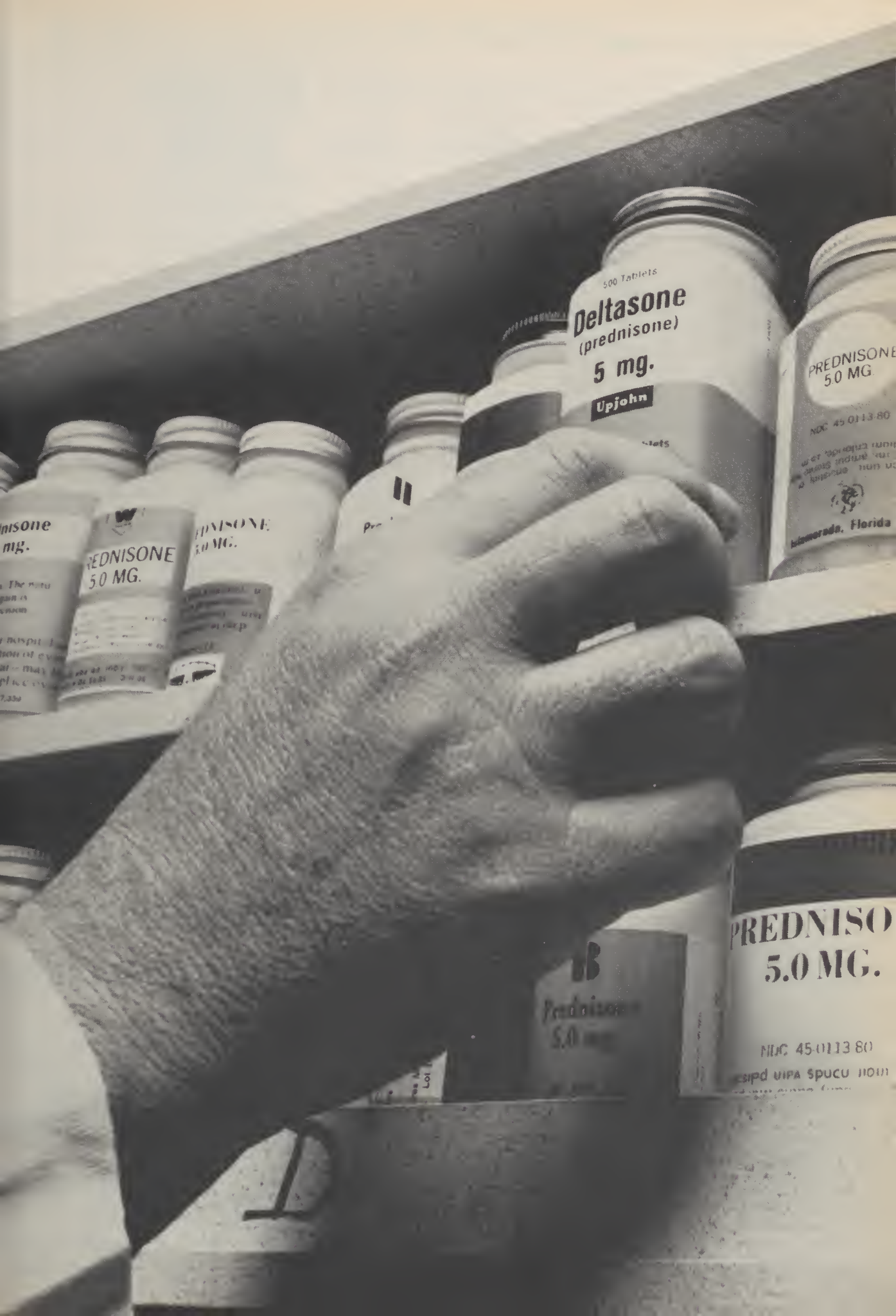
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The potency of prednisone exceeds cortisone in glucocorticoid and anti-inflammatory activity by about five times on a weight basis, but is considerably less active than cortisone in mineralocorticoid activity.

Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. *Important:* Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptomatically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance doses of Deltasone (prednisone), however, keep this effe in mind and perform periodic serum potassium determinations patients on prolonged corticoid therapy. Muscle weakness occu ring with normal serum potassium levels may be due to disturban in muscle metabolism. Severe myopathy is associated with su stantial doses of steroids for prolonged periods, and eviden indicates it occurs more frequently with 9-alpha-fluro steroids. R placement with non-fluorinated steroid has, in some instances, sulted in improvement.

Retardation of linear growth, roughly proportional to dose, h been noted in children on corticoids for six months or more. Follo ing cessation of therapy, growth rate may be accelerated. Ther fore, carefully observe growth of children on prolonged cortico and if growth is retarded, reduce dose sufficiently to permit recov before epiphyseal closure. Make every effort to avoid corticoi during pregnancy, since spontaneous remission of some disea such as rheumatoid arthritis may occur. Long term corticoid thera may evoke hyperacidity or peptic ulcer, therefore, as prophylax an ulcer regimen and antacid are highly recommended. Take X-ra in peptic ulcer patients complaining of gastric distress, a whether or not changes are noted, an ulcer regimen is reco mended. Since prednisone causes less salt and water retenti than many other glucocorticoids, patients should be obser closely for development of undesirable hormonal effects that a less obvious indications of steroid toxicity than edema and hyp tension due to salt and water retention. Continued supervision patients after cessation of therapy is essential, since there may a sudden reappearance of severe disease manifestation.

Adverse Reactions: Adverse reactions associated with use of co coids include: Cushing's syndrome, moon facies, supraclavicu fat pads, hirsutism, striae and acne; relative adrenocortical insu ciency particularly in time of stress due to trauma, surgery severe illness; protein catabolism with negative nitrogen balan electrolyte imbalance; alteration of glucose metabolism with agg vation of diabetes mellitus including hyperglycemia and glycosu osteoporosis reversible only with difficulty; spontaneous fractur aseptic necrosis of the hip and humerus; activation and compli tion of peptic ulcer including perforation and hemorrhage; agg vation or masking of infection; increased blood pressu convulsions; petechiae and purpura; menstrual irregularities cluding amenorrhea, spotting or prolonged bleeding; insomn psychic disturbances especially abnormal euphoria; nervousne posterior subcapsular cataracts occasionally requiring extracti increased intraocular tension; increased intracranial pressure v papilledema (pseudotumor cerebri); pancreatitis; necrotizing ar itis; thinning of scalp hair; suppression of growth in childr thromboembolic complications; facial erythema; allergic skin re tions; ulcerative esophagitis; sweating; vertigo; weakness; my athy; headache; exophthalmos. Adverse reactions are usu reversible and usually disappear when drug is discontinued.

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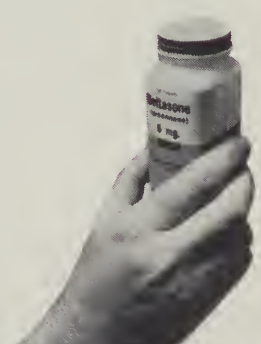

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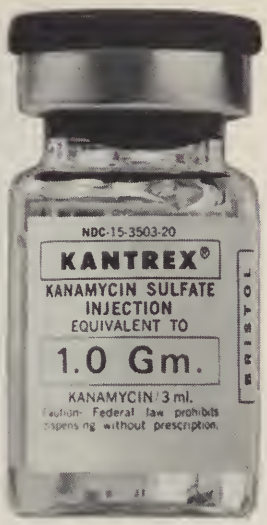

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Warning: Irreversible deafness can occur. Tinnitus or vertigo may also occur and indicate vestibular damage and impending deafness. The risk is sharply increased with renal dysfunction. In such cases, decrease size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. Watch carefully for ototoxicity in older patients and patients receiving more than 15 Gm of kanamycin. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in post-operative patients until recovery from anesthesia and muscle relaxants is complete. Avoid concurrent use of other ototoxic drugs including ethacrynic acid. Safety in pregnancy is not established.

ndications: Serious infections due to susceptible strains of *E coli*, Proteus sp. *nterobacter aerogenes*, *K. pneumoniae*, *Serratia marcescens* and *Mima erellea* Culture and sensitivity studies should be performed.

ontraindications: A history of hypersensitivity to the drug Prior auditory damge by kanamycin or other agents may be a contraindication if effective alternave therapy is available.

recautions: Obtain audiograms before and during therapy in patients with renal dysfunction when treatment lasts more than 5 days. Stop Kantrex if tinnitus or hearing loss occurs. Hydrate patients to prevent chemical irritation of the renal tubules Assess renal function periodically, both before and during therapy If signs of renal irritation occur (casts, cells, proteinuria) increase hydration and reduce the dosage or the frequency of dosage if necessary – in azotemic patients the frequency (in hours) of doses may be obtained by multiplying the serum creatinine by 9 If azotemia or oliguria occur, discontinue therapy. Mycotic or bacterial superinfection may occur.

Adverse Reactions: Irritation or pain at the injection site, skin rash, drug fever, headache and paresthesias.

Dosage and Administration: The maximum total daily dose should not exceed 1.5 Gm. by all routes of administration. The usual dose is 7.5 mg./Kg./12 hours I M. The average adult dose is 1 Gm. daily. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours.

If no response occurs in 3 to 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours. The drug should not be physically mixed with other antimicrobials.

Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations: 0.5 Gm. in 2 ml. and 1.0 Gm. in 3 ml. Also available – Pediatric Injection 75 mg in 2 ml.

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PENNSYLVANIA MEDICINE

capitol report

CHIROPRACTIC MEASURES HIT LAWMAKERS Three bills, House Bills 816, 817, and 818, have been introduced, all at the same time, all referred to the same committee — the Committee on Professional Licensure, and all with the same chief sponsor, Ulysses Shelton of Philadelphia, who also is chairman of the Committee on Professional Licensure. H.B. 816 would require insurance companies to pay for chiropractic services when the company pays other practitioners for similar services. H.B. 817 is an amendment to the Chiropractic Practice Act which would permit the Board of Chiropractic Licensure to promulgate and enforce rules of "professional" conduct appropriate to establish and maintain a high standard of integrity and dignity in the profession of chiropractic." H.B. 818 would amend the so-called "Statutory Construction Act," which defines many of the terms used throughout the state's legal code, to include chiropractors under the term "physician" as well as doctors of medicine and osteopathy. With regard to the last bill, PMS President William A. Limberger, M.D., wrote to members of the licensure committee to express the State Society's "strong opposition to... House Bill 818, Printer's No. 902... The present definition is a medical one and is confined to practitioners of medicin namely doctors of medicine and doctors of osteopath medicine."... Chiropractors are campaigning diligently f passage of these bills, going so far as to claim throughou the state that results of a York County poll of M.D.'s sho that half of the York County doctors do not oppos licensing of chiropractors despite the official position of o position of both the county society and PMS. The Yor County Chiropractic Society based its statement on the a sumption that no reply from a physician is construed as favorable reply for chiropractic licensing.

THREE ABORTION BILLS BEFORE LEGISLATURE Two House bills, Nos. 526 and 800, and or Senate bill, No. 617, are under consideration in the Legisl ture. H.B. 526, introduced in March and detailed on pag 38 of the April issue of PENNSYLVANIA MEDICINE, is th so-called "abortion on demand" bill, which essentially giv a woman the right to seek an abortion so long as she mak known her intent before the sixteenth week of pregnanc H.B. 800 is the antithesis. It would ban all abortion stating, "The Commonwealth of Pennsylvania affirms i immemorial recognition that all human life is inviolable...

Both bills have been referred to the Committee on Healt and Welfare. S.B. 617, referred to the Rules Committe would permit abortions under specific circumstances. Th bill would permit abortions by physicians if the pregnanc resulted from rape or incest or would result in the death the mother. The bill also defines illegal abortion, ar permits abortion only in accredited hospitals on state res dents. It also would ban advertising of abortion services ar abortifacients. Meanwhile, the Pennsylvania Supreme Cou is to hear a Centre County case on the constitutionality the present law, and the United States Supreme Cou recently upheld a 1901 Washington, D.C. law whic approves prosecution of physicians who perform abortio but says pregnancies can be ended legally for mental healt reasons. The U.S. Supreme Court has said it will consid cases involving the abortion laws of Texas and Georgia. decision is not expected until late in 1971.

July 4, 1971
195 Years of freedom

Independence Hall, Philadelphia

Shazam!

In this issue of PENNSYLVANIA MEDICINE the paper by Glaser, on page 51, makes two points which merit special emphasis.

All too often drug abusers are approached by family, friends, and physicians alike, exhorting the patient to discontinue the practice of drug abuse because of the harm they inflict upon themselves. Such insistence solves none of the patient's problems, since drug abuse "in its essence is a self-destructive act." The distorted mind of the drug abuser simply cannot understand such appeals to reason, which will only frustrate therapeutic efforts if this fact is not understood.

Non-psychiatric physicians are involved in the management of drug abusers in three areas: (1) medical management of the acute effects of one or more drugs due to indiscriminate use, (2) prevention of drug abuse not only as physicians but as concerned citizens and parents, and (3) continuing care of drug abusers to help in their rehabilitation. Obviously, the management of the acute effects is one thing, but prevention and discontinuance of drug abuse is another.

Dr. Glaser has suggested a solution. He calls for strong moral leadership from the older, much wiser and more experienced citizens for the youth of America. Physicians, by working together with others in their communities, can give this kind of leadership. No one is better suited to undertake such an important role in helping solve the drug abuse epidemic than the knowledgeable, understanding, and compassionate physicians practicing in the communities across our Commonwealth and nation.

DAS

Public Expectation and Realization

There is a growing concern among medical and non-medical scientists about yet another gap — the gap between public expectations and the realistic limitations of scientific performances. This gap has created an unfavorable public attitude toward the scientific community which can only hinder its endeavor.

As an example, the racial and anti-war demonstrations of the past few years caused considerable adverse public reaction against our institutions of higher learning. These institutions were expected by the public to have the solutions that should have prevented these events. By virtue of this attitude these institutions have been labeled as failures and even worse, etiological agents for the "sick society."

Along with other professional organizations and institutions, organized medicine has really just begun to feel the full impact of this expectation — performance gap. As organized physicians begin to develop an ever-giving relationship between the private practice of medicine and the federal government, there are promises being made that this partnership will solve the problems of the health care system. Organized medicine as the private partner of this relationship is being given the responsibility for the solution of all of these problems. Can it respond to these challenges and meet public expectation or demand?

Can this partnership between government and a cooperative medical profession meet the public demand and still permit the profession's needed independence? If the demands prove to be unrealistic and unattainable, will it lead to further outside interference, more governmental regulation of the health care industry, and more malpractice suits by a disgruntled public? If productive medical research, quality medical education, and patient care are the goals of this partnership, an atmosphere of public acceptance of the medical-scientific communities' limitations is essential if it is to be a successful partnership.

The recent destruction of this country's medical research establishment by the federal government will have immeasurable detrimental effects in the future. This destruction resulted from total dependence on federal revenues, overconcern with the problems of the current health care delivery system, and overselling of our research capability. Now the politicians are making promises that National Health Insurance will solve the problems of health care costs and the shortage of physicians.

Promises made and not kept can only lead to further public dissatisfaction and ultimately to further deterioration in the quality of medical care, education, and research. Long-term benefits can be achieved only by maintenance of proper checks and balances in the cooperative efforts of government and the private sectors. Bureaucratic inefficiencies and ineffectiveness must not be a substitute for a viable medical care system.

DAS

Do unmet needs of patients foster cultism?

PMS COUNCIL ON PUBLIC SERVICE

We physicians are inconsistent when we grumble about chiropractic and then do not meet certain needs that propel patients to seek understanding— even if it is from a cultist.

We may argue— with some validity— that we don't have time to hold hands with and listen to the emotionally distraught patient who needs empathy, directive suggestions and "the laying on of hands" much more than he or she needs a gaily colored pill.

Perhaps we don't have time but the cultist does.

That, essentially, is the reason the chiropractor exists.

There are other reasons for the phenomenon— the cult— of chiropractic. In the general public there is an irreducible minority of persons from many walks of life who is opposed to the mainstream of any science or discipline and who demonstrates that opposition by turning to those who exist on the fringes of science. Perhaps the "why" of that opposition can be delineated, but it generally defies easy explanation. Apparently, this part of the phenomenon would exist no matter how abundant, understanding and skillful physicians would be.

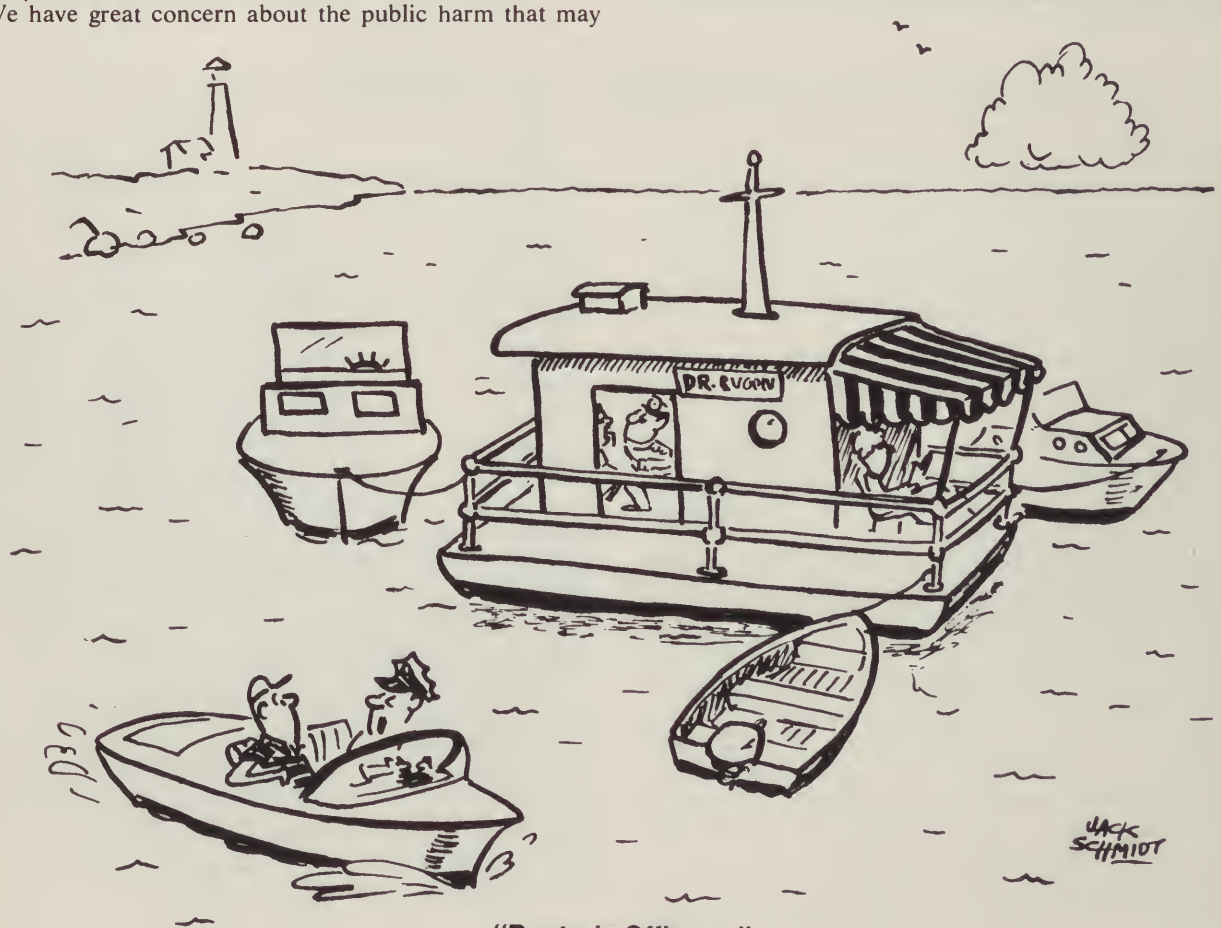
The majority of patients who turn to such things as chiropractic is a reducible number but it won't be reduced significantly by criticism of the theory and practice of the cult of chiropractic, no matter how justified that criticism is.

We have great concern about the public harm that may and does occur when backbone thumping is substituted fo care in the mainstream of science, but the backbon thumpers will flourish for as long as physicians are unabl or unwilling to inject rapport as well as drugs.

Chiropractic should not exist. Its far-out theory defie logic and far too many patients dangerously delay gettin the care they really need while they respond emotionally t the verbal suggestions and vertebral poundings of the chiro practor.

However, even if chiropractic is legislated out of exist ence, something equally absurd will spring up to take it place. That "something" has some predictable elements: it operator will work in an unhurried atmosphere; the fees wi be high to impress the patient; it will consist essentially o verbal and non-verbal suggestion, constantly reinforced b extensive physical contact between the operator and pa tient— the "laying on of hands;" it will have impressiv looking gadgetry with flashing lights and strange sounds and, perhaps above all, it will have no scruples about adver tising its claims.

If we physicians do not have time to treat the whole pa tient, then someone under our supervision should, for if tha someone does not exist within the medical team, he wil exist outside of it to the detriment of good health care.



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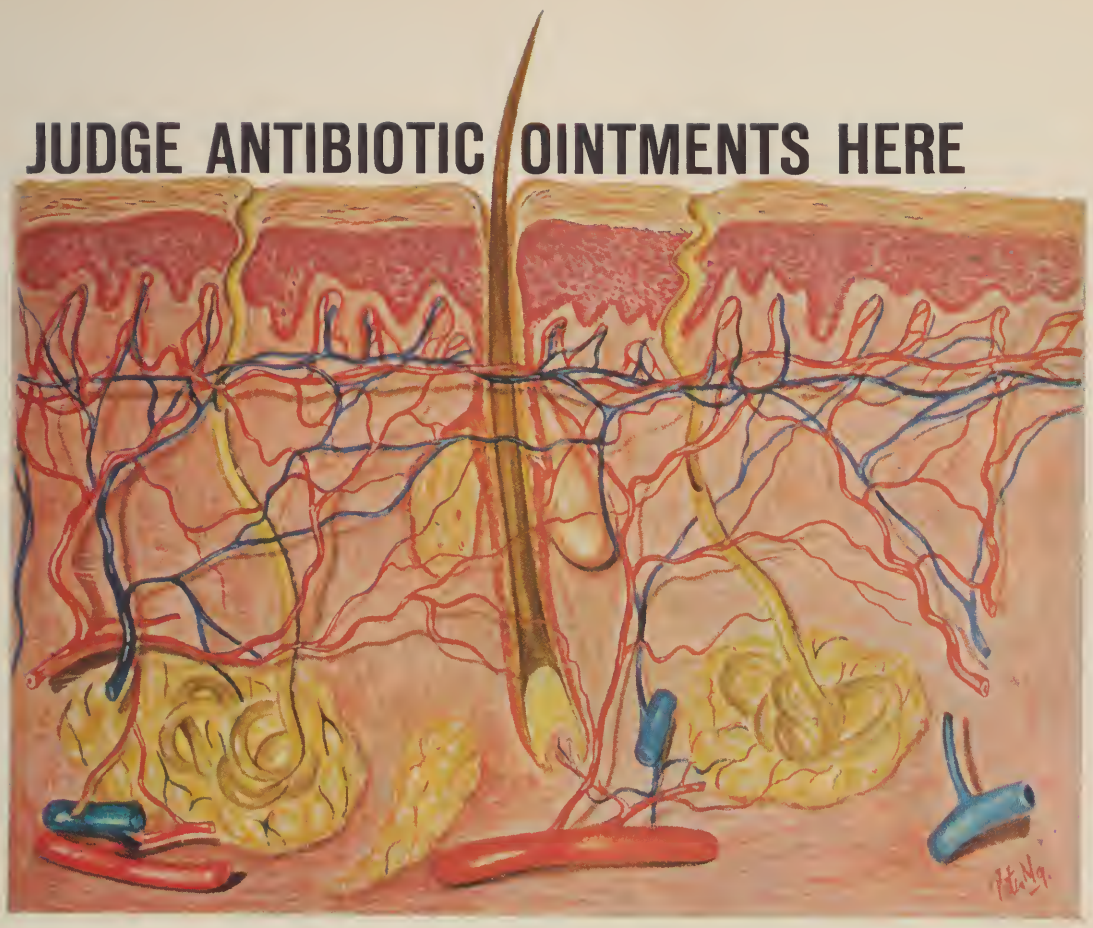

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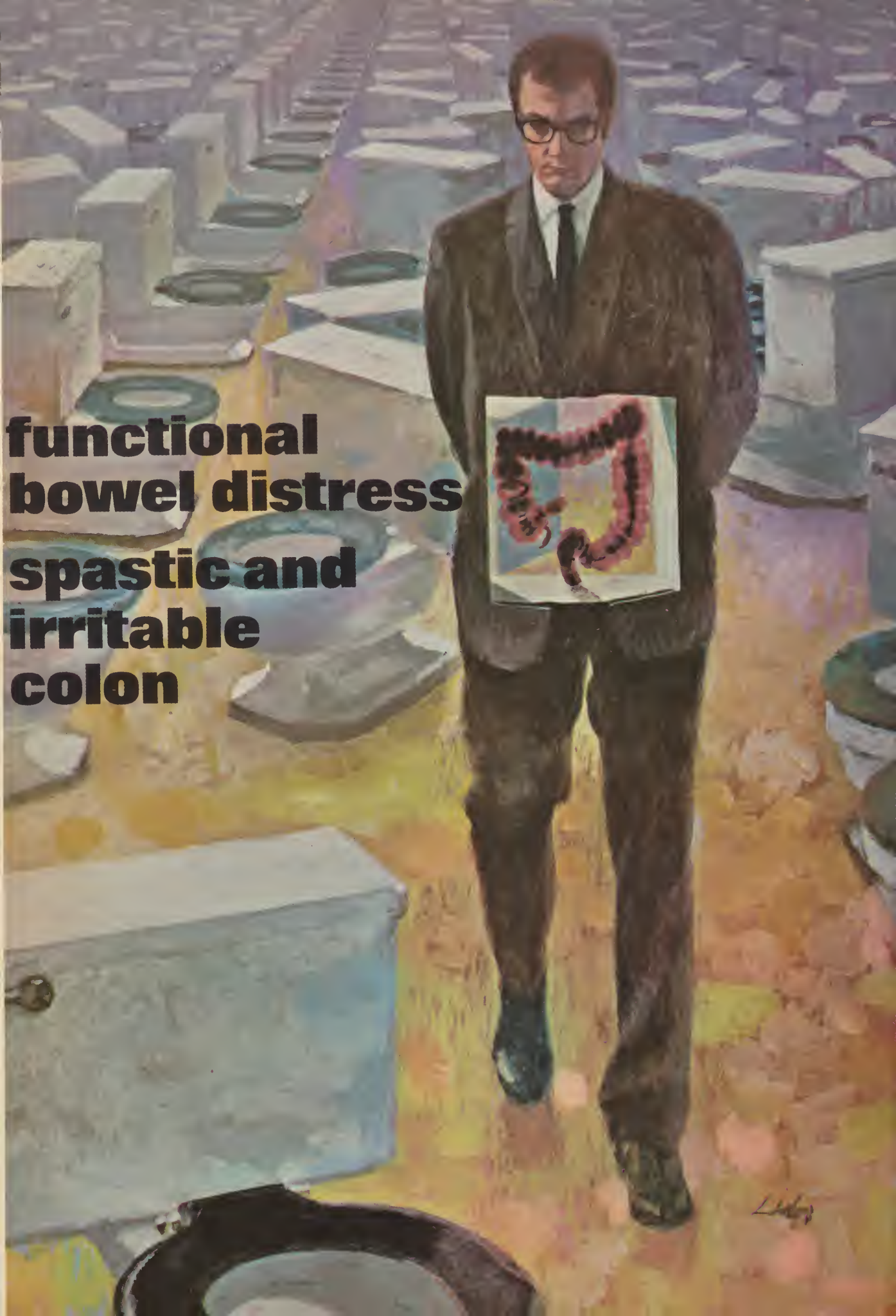
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bowel distress
spastic and
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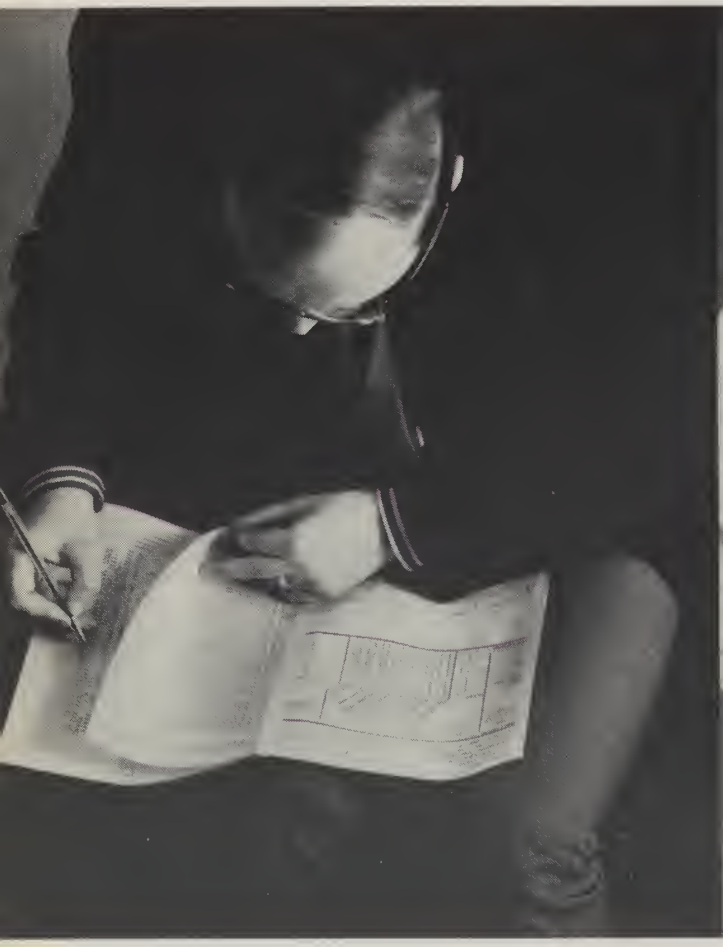

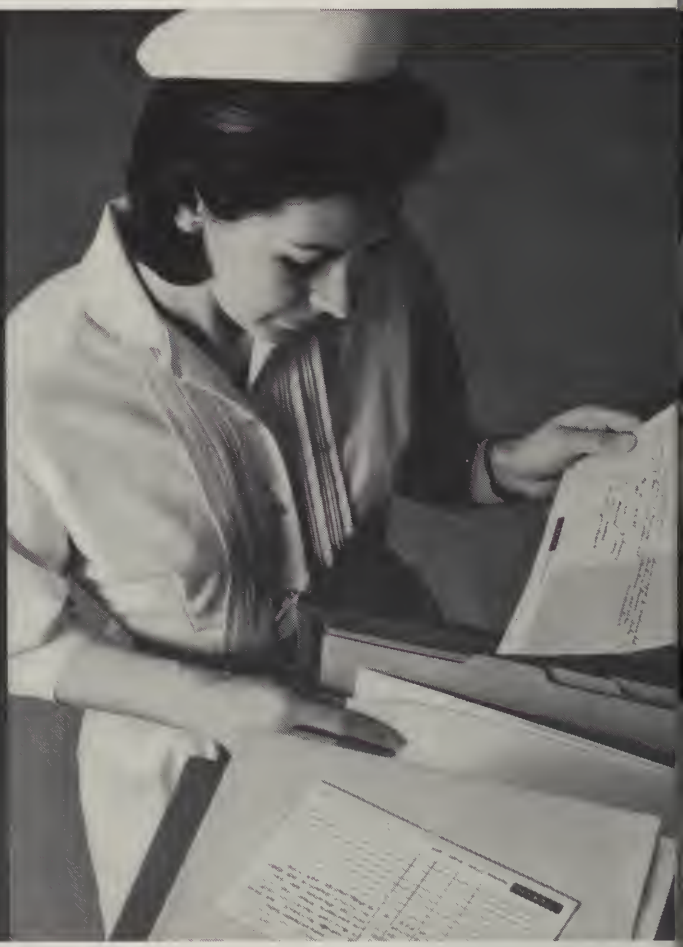

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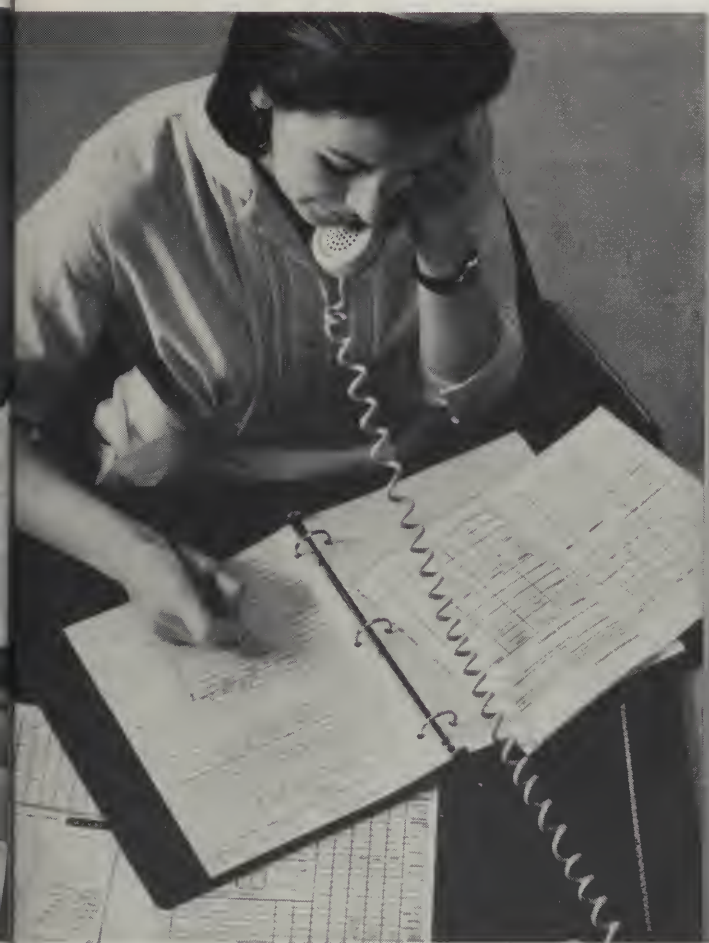

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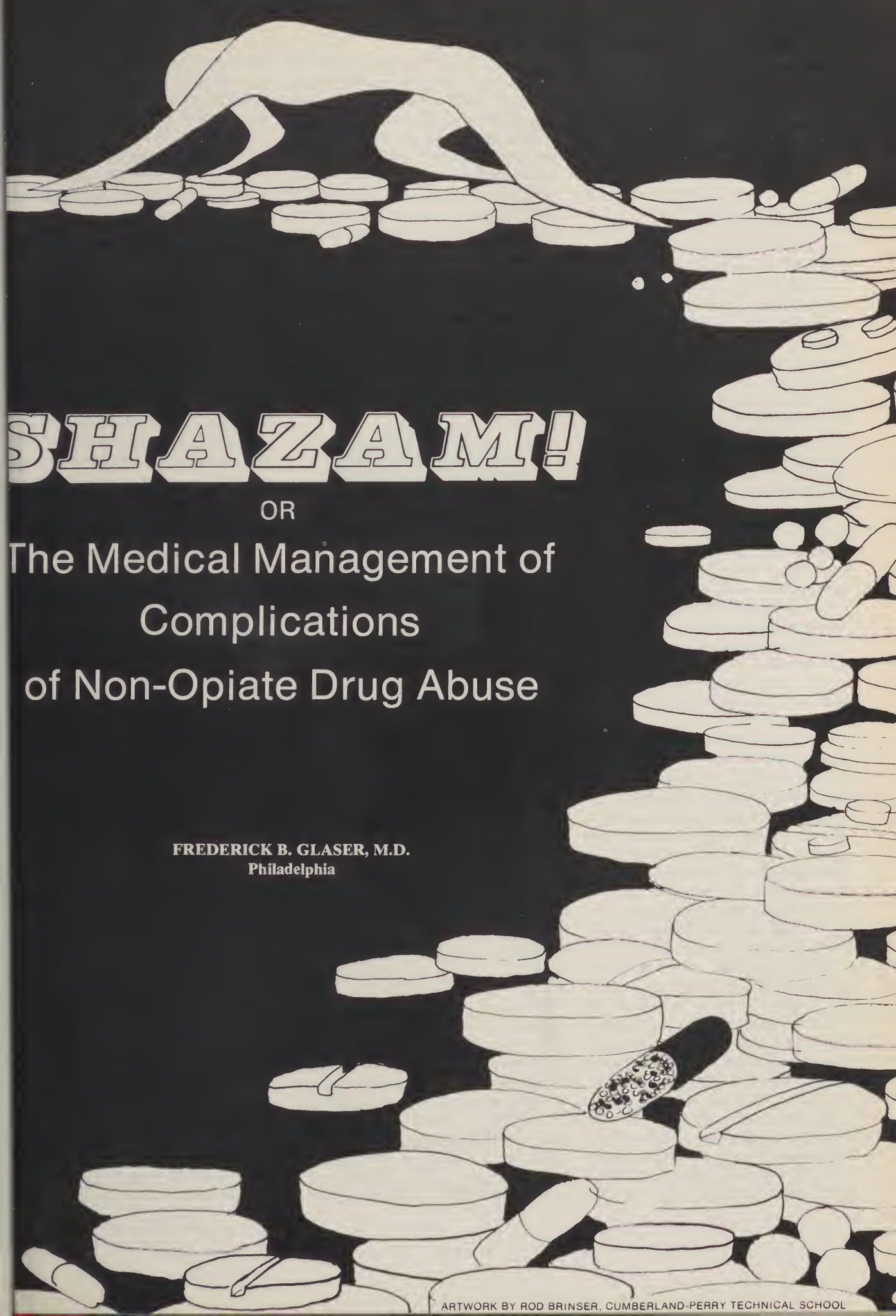


SHAZAM!

OR

The Medical Management of Complications of Non-Opiate Drug Abuse

FREDERICK B. GLASER, M.D.
Philadelphia

ARTWORK BY ROD BRINSER, CUMBERLAND-PERRY TECHNICAL SCHOOL

THE MODERN FAMILY physician is faced with the many and complex sequellae of non-opiate drug abuse.For a number of reasons this is an extraordinarily difficult aspect of medical practice. Unfortunately, it is one which is likely to be encountered with increasing frequency. The Uniform Crime Reports for Drug Law Violations indicate that between 1964 and 1968 violations increased more than 281 percent in the cities, more than 375 percent in rural areas, and, amazingly, more than 1,024 percent in suburban areas. The bulk of this increase was among persons less than 18 years of age. The increase for dangerous drug arrests was in excess of 356 percent, and that for marihuana arrests was in excess of 695 percent for the same period, both figures far outstripping the increase rate for heroin, cocaine, and synthetic narcotics.[1] Although the relationship of arrest-rate figures to actual use is open to some question, the error is almost certainly on the side of underestimation.

Without doubt, the burden of this problem will fall upon the general physician, who could make use of the power which the comic book character, Billy Batson, was given by the aged prophet, Shazam, enabling Billy to go forth into the world and battle evil as the incomparable Captain Marvel.[2]

The psychiatrist may eventually be asked to treat long-term aspects of the problem, but it is the general medical man who will be confronted with the emergency situations produced by drug abuse and who will have to deal with the patients and to know which techniques should be used.

Problems in Obtaining an Accurate History

Traditionally the first line of defense against disease in medicine has been the obtaining of a detailed and comprehensive history of the problem. Most of what follows will be based on the insights gained in this process. Unfortunately, obtaining an accurate history on an individual suffering from a complication of drug abuse is often difficult or impossible. The individual may fear arrest and be reluctant to state what he has taken, even though ingesting the substance is not in itself a crime. This legal distinction is often lost upon the frightened drug abuser and, if he is young enough, he knows it will not protect him from the wrath of his parents. He may attempt to mislead the physician and say he has taken something other than he did. He may not know what he has taken. Pointing out that he is harming himself by hiding the truth does not help, because drug abuse in its essence is a self-destructive act, and appeals to reason usually fall upon deaf ears. Some information may be obtained through friends and relatives or from laboratory analyses of any remaining medication or of gastric washings; but in most cases that potent and customary tool, the careful history, will not be available to the physician.

Pitfalls in Evaluating the Physical Findings

Many aspects of the physical examination depend upon the patient's response to the actions of the physician. In the drugged state, these reactions may be altered in unpredictable ways. If the patient is delirious or comatose, he will not be able to cooperate. One of the most potentially serious problems is the misinterpretation of some findings as being secondary to the drug state when they are, in fact, secondary to an intercurrent and unrelated disease process.

For example, in a series of five cases reported from New York City, signs and symptoms of abdominal pain were thought to be due to drug withdrawal, but at autopsy serious intra-abdominal pathology was discovered.[3] In a case in Philadelphia, a medical student who had taken LSD was treated for his symptoms with a phenothiazine derivative. Unfortunately, the student had a previously unsuspected pheochromocytoma. It has been alleged that his death was due to a paradoxical reaction to the phenothiazine which was greatly enhanced by his unsuspected underlying disease.[4] The physician must, therefore, be alert to the possibility that a patient brought to him as suffering from a complication of drug ingestion may have more than one problem requiring medical attention. Indeed, certain kinds of medical problems are more likely to be seen in drug abusers than in other (e.g., subacute bacterial endocarditis). These have been well reviewed in the literature.[5 6]

Indiscriminate Use of Drugs

Although one may gather that the physician's task is not simple, it might be easier if the kinds of substances used by non-narcotic drug abusers were limited in nature. Recent experience indicates, however, that there are a growing number of individuals who will put almost anything into their mouths and eat it, or even worse, will inject almost anything into their veins. The results, as Hamlet might have said, defy augury; it is hard to predict what will happen. For example, it has recently been reported that a major proportion of convulsive disorders among U.S. troops in Vietnam are the result of their ingesting a plastic explosive material, called "Composition C4." Its main chemical component is something called cyclotrimethy lenetrinitramine. At reduction, its products include methylamine, nitrous acid, ammonia, and formaldehyde. Severe renal failure requiring hemodialysis has been seen in at least three patients.[7] In another reported instance, eleven prisoners were hospitalized over a two-day period with an acute febrile illness accompanied by septic retinitis. After investigation, it was discovered that four of them had ingested and seven had injected into their veins a homemade alcoholic beverage prepared in old paint cans containing table sugar, baker's yeast, canned peaches and potato peelings. Cultures of this concoction yielded streptococcus viridans, an unidentified gram-negative rod, and yeast.[8] There have been reports of people inhaling hair spray, anti-tussive aerosol or frying pan cleaner and suddenly dying, presumably due to fatal cardiac arrhythmias,[9] or ingesting morning-glory seeds, inhaling laughing gas, and smoking catnip and banana peels.[10-13] Their effects range from the non-existent to the psychotic and the potentially fatal. In short, we seem to have entered an era of pharmacological promiscuity unprecedented in history. Perhaps it is a sign of the times. Dr. Samuel Johnson once remarked: "I look upon it, that he who

does not mind his belly, will hardly mind anything else."

Use of Combinations of Drugs

To compound difficulty upon difficulty, many of these drugs are not taken singly but in combination with each other. The physician may not often be able to understand the patient's problems as being the result of the abuse of a single drug, but will increasingly find that he will have to take into account the simultaneous abuse of several drugs, and will have to attempt to puzzle out how they are interacting with each other and with the patient to produce the observable symptoms. The possible combinations of drugs are countless. Two examples will be given from the Philadelphia area. In 1969, a Hahnemann physician reported the case of a 19 year old college student who had smoked three marihuana cigarettes which had been previously soaked in a scopolamine solution. Within thirty minutes she became agitated, combative and delusional, with both auditory and visual hallucinations of a frightening nature. Hospitalization was required.[14] During the previous year, a physician at the Hospital of the University of Pennsylvania had reported four cases of a toxic psychosis due to the ingestion of variable amounts of Asthmador powder, a mixture of stramonium and belladonna. The patients all exhibited a severe organic brain syndrome with formication.[15] From Detroit we hear of a combined addiction to paregoric and tripelennamine, called "Blue Velvet" addiction. Two deaths from pulmonary hypertension are reported; the talc which is used as a filler in the tripelennamine tablets formed thrombi which were trapped in the pulmonary vascular bed, and the ensuing granulomatous reaction caused the fatal pulmonary hypertension.[16] These cases also illustrate the fact that combinations of non-opiates with opiates are not rare.

Use of Impure or Contaminated Drugs

The illegal market in drugs has no organization analogous to the FDA to guarantee the quality and purity of its products. Thus the physician may be called upon to deal with the effects, not of any known drug, but of some exotic contaminant produced by the weird alchemy of an earnest but decidedly amateur illegal laboratory. Law enforcement officials who have raided such establishments routinely remark upon their lack of cleanliness and often their gross contamination. This would lead one to expect all manner of serious infectious complications of the use of illegally manufactured drugs, including such serious problems as botulism. There are also problems of mislabelling and dosage. A study conducted in Princeton, New Jersey, looked at a sample of drugs which were said to be representative of the illegal market over a three-year period. It found that although most of the samples which were sold as LSD did in fact contain it, the dosage ranged from 50 to 283 micrograms in tablets which were supposed to contain a fixed amount of the drug. None of the samples which were supposed to contain psilocybin, mescaline or tetrahydrocannabinol contained any of these substances. Four of the samples said to contain mescaline in fact contained STP or dimethoxymethylamphetamine, an extraordinarily dangerous drug. Three of the samples contained Sernyl (phencyclidine), a drug which produces a severe toxic psychosis.[17] This and other similar studies provoked the following comment from the newsletter of a student organization concerned with the study of hallucinogenic drugs:

> It seems a sad commentary on the state of the present "psychedelic subculture" that the very practices of the establishment which are criticized as hypocritical (a lack of "truth in packaging" and the slick merchandizing techniques of Madison Avenue) are the same practices employed by the purveyors of our chemical sacraments.[18]

To summarize, because of the difficulties involved in both history and physical examination in the non-opiate drug abuser, and because of his indiscriminate use of a bewildering variety of drugs which may be combined with other drugs, may be impure, or may be contaminated, the physician may well find that he is attempting to deal with clinical material which will tax the very limits of his diagnostic acumen, his ingenuity, and his effectiveness. Nor have we exhausted by any means the possible difficulties which may be encountered. For example we have generally adhered to a largely artificial distinction between opiate and non-opiate drug abuse. In the interests of clarity and brevity the management of various kinds of drug problems will next be discussed, but one should be on guard lest the organization of the

ARTWORK BY BRIAN SMITH, CUMBERLAND-PERRY TECHNICAL SCHOOL

Trapped

material for presentation again appear to simplify a problem which is very complex indeed.

Specific Treatment Problems

The effects of specific drugs on individuals are extremely variable and depend upon the interaction of a number of factors including the properties of the drug, its dosage, the frequency with which it is taken, the psychological, social, and biochemical nature of the individual at the time the drug is taken, and the setting— where it is taken, when it is taken, with whom, and so forth. However, Wikler[19] has observed that with at least some of these drugs, the relative importance of variables other than the properties of the drug tends to decrease as the dosage increase, until at very high doses the syndrome observed is almost exclusively due to the properties of the drug, with other variables playing a decidedly minor role.

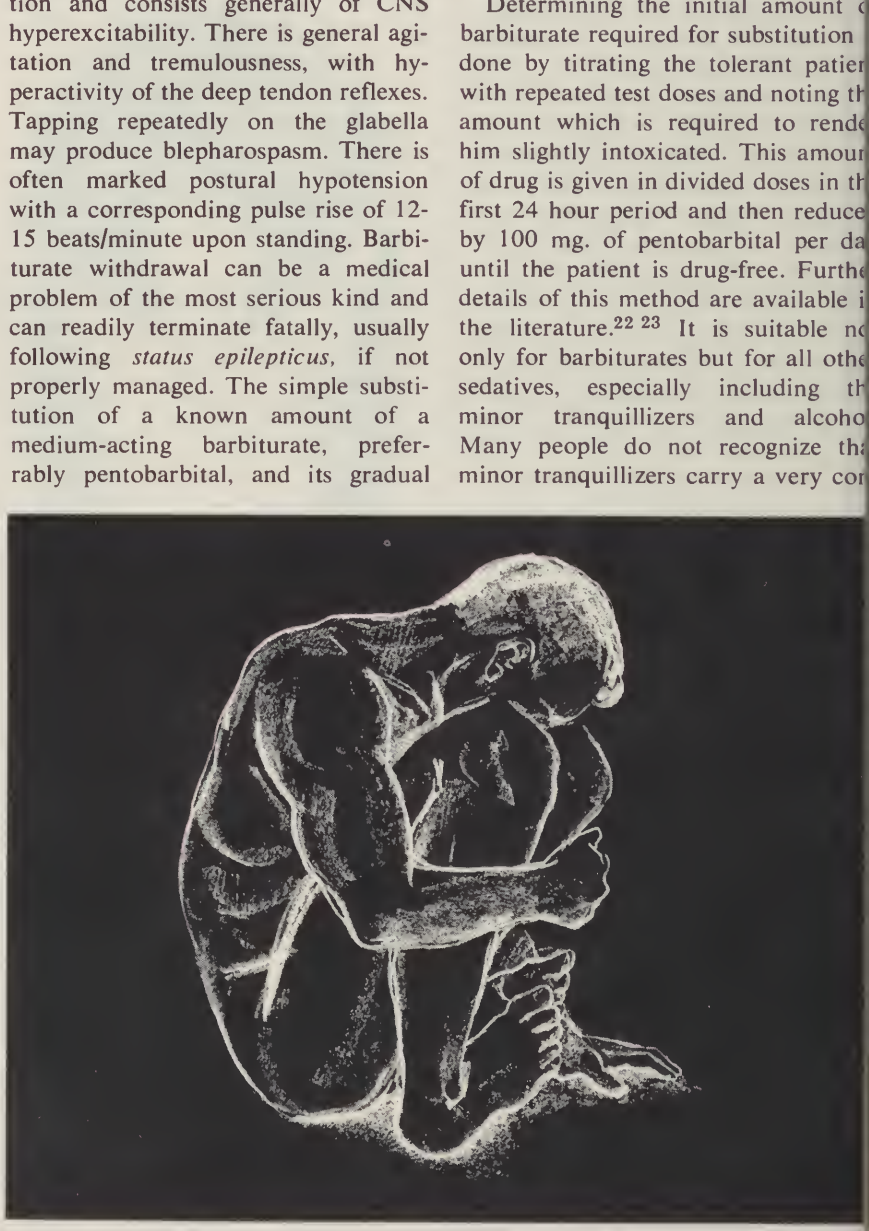
Thus for any drug, even within the same individual, one might expect to see a spectrum of drug-related behaviors, rather than one, "classical" syndrome. This makes the description of the effects of specific drugs rather difficult. It is as well somewhat redundant, since the literature in medicine, psychiatry and pharmacology contains many such descriptions. Although a summary of the specific effects of some of the major drugs of abuse will be essayed here, and some particulars of specific treatment will be discussed, the coverage of this aspect of the management of non-opiate drug abuse will be idiosyncratic rather than comprehensive. For those wishing a more thoroughgoing treatment of this subject, an excellent review article has recently appeared.[20]

Barbiturates and Other Sedatives

Most people are familiar with the clinical picture of barbiturate overdosage in its mildest forms; it is exactly similar to that of alcoholic intoxication, with slurred speech, shuffling gait, and nystagmus on lateral gaze. In its more serious form barbiturate intoxication can produce a coma so profound that the EEG becomes isoelectric[21] and all deep tendon reflexes disappear. This latter condition is often seen in non-addicts who attempt suicide by taking barbiturates. Management of the less severe form often requires only simple abstention from the drug. The more severe form requires hospitalization, removal of airway obstruction if any exists, oxygen and, if respiratory failure is impending, some type of mechanical assistance for respiration. Hemodialysis may also be considered, and occasionally pressor amines are necessary. Gastric lavage is important initially; a large amount of medication which may subsequently cause trouble may be removed.

The clinical picture of barbiturate withdrawal is less familiar; however, it is the obverse of barbiturate intoxication and consists generally of CNS hyperexcitability. There is general agitation and tremulousness, with hyperactivity of the deep tendon reflexes. Tapping repeatedly on the glabella may produce blepharospasm. There is often marked postural hypotension with a corresponding pulse rise of 12-15 beats/minute upon standing. Barbiturate withdrawal can be a medical problem of the most serious kind and can readily terminate fatally, usually following *status epilepticus,* if not properly managed. The simple substitution of a known amount of a medium-acting barbiturate, preferrably pentobarbital, and its gradual withdrawal under medical supervision will obviate these dangers. Not all individuals exhibiting symptoms of barbiturate withdrawal, or giving a history of barbiturate or other sedative intake, will require substitution. A simple test will show whether substitution is required. The patient may be given 200 mg. of pentobarbital orally and examined for signs of barbiturate intoxication after one to two hours. A person taking only a small amount of sedative drug, or none at all, will exhibit obvious signs of intoxication on such a trial. If no signs of intoxication are evident the individual is tolerant to barbiturates (or cross-tolerant to them) to a degree which indicates that substitution-withdrawal is necessary.

Determining the initial amount of barbiturate required for substitution is done by titrating the tolerant patient with repeated test doses and noting the amount which is required to render him slightly intoxicated. This amount of drug is given in divided doses in the first 24 hour period and then reduced by 100 mg. of pentobarbital per day until the patient is drug-free. Further details of this method are available in the literature.[22 23] It is suitable not only for barbiturates but for all other sedatives, especially including the minor tranquillizers and alcohol. Many people do not recognize that minor tranquillizers carry a very con-

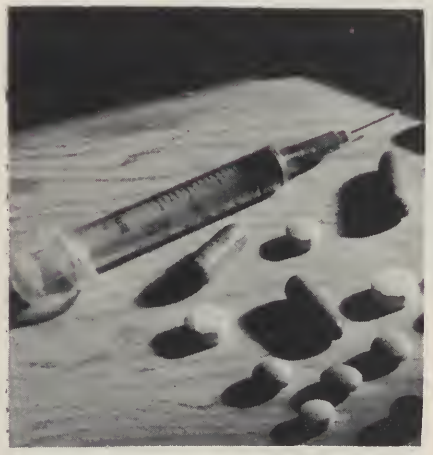


siderable abuse potential and can cause serious problems upon withdrawal.[24] The most severe withdrawal syndrome the author has even seen occurred in a man who was addicted to meprobamate and was taking a phenomenal 20 grams per day. It is also worthwhile pointing out that the use of diphenylhydantoin is of no value in protecting the individual against seizures due to drug withdrawal, probably because they are multifocal in origin.[25]

Amphetamines and Other Stimulants

In moderate doses these drugs produce a syndrome of excitability, with increased wakefulness and alertness and the subjective impression of enhanced performance efficacy. In larger doses, especially if taken intravenously, a series of hyperexcitable states extending into delirium and psychosis may be seen. Although LSD and other drugs have been frequently referred to as "psychotomimetics," it has been categorically stated that the clinical syndrome induced by excessive use of amphetamines has "a closer resemblance to schizophrenia than that produced by any other known hallucinogenic drug."[26] There are some differentiating points, such as a predominance of visual hallucinations and absence of a thought disorder in amphetamine psychosis; but they are not invariable, and are likely to be useful diagnostically only to the psychiatric specialist. One study[27] has been cited as evidence that a sufficient dose of amphetamine could produce such a psychosis even in a normal person. The methodology of the study does not in fact support this conclusion, nor would it be ethically feasible to do the critical study. Nevertheless the conclusion is in all probability correct. Acute amphetamine intoxication may terminate fatally. It is worth pointing out, however, that in spite of statements in the literature to the contrary there is as yet no conclusive evidence that amphetamines produce organic brain disease.[28]

One of the most dramatic events on the addiction scene in recent years has been the appearance of the compulsive abuser of high-dosage intravenous methamphetamine— the "speed freak." He injects his drug from one to ten times per day, with each injection experiencing a "flash" which he describes as a "total body orgasm." This pattern, called a "speed binge" or a "run," may last for several days, during which the individual does not sleep and rarely eats. It terminates because of fatigue, confusion, paranoia, or lack of supplies, and is followed by a period of extreme exhaustion and depression. Often another "speed run" is begun by the user to bring himself out of the depressive phase.[29] This series of unusual events corresponds much more closely than does narcotic abuse to the early formulations of Rado[30 31] regarding addiction, developed before "speed freaks" had ever been known.



Most of the acute toxic manifestations of this group of drugs will subside with watchful waiting and the precaution that further supplies of drugs are not available for use. Sedation with barbiturates or such drugs as chlorpromazine or diazepam is helpful. In serious overdosage cases it may be necessary to take steps to combat hyperpyrexia and increased intra-cranial pressure. In one large series of cases of methamphetamine abuse, the most frequent medical complication other than general debility with malnutrition was hepatitis, which occurred in 61 of 310 patients, or almost 20%.[32] Other complications included infections, GI symptoms including abdominal cramps severe enough to make one suspicious of appendicitis, and cardiorespiratory problems, especially tachycardia and dyspnea. It has been speculated that the hepatitis is due not only to the use of contaminated equipment but that it may be a direct effect of the drug. Unless dealt with in some manner, the depressive reaction which follows abuse of the drug may be the occasion of renewed abuse.

Recently a new series of drugs has appeared which are chemically related to the amphetamines and which have the physiologic effects of this series of drugs but which have psychological effects more nearly resembling those of LSD. The best known of these has been popularly called STP. Chemically it is 2,5-dimethoxy-4-methylamphetamine. The usual "street" dose is 10 mg; at this level, the effects of the drug often last 16 to 24 hours, rather than 8 to 10 hours as with LSD.[33] Because of the intensive physiological effects, which resemble those of atropine, it was thought for some time that the use of drugs such as chlorpromazine, which have a pronounced anticholinergic, atropine-like effect, were contraindicated. Experimentally, however, this does not appear to be the case.[34] Given the propensity of today's abusers to use more than one drug, it may be difficult to be certain whether the atropine-like effects in a given individual are due to STP or whether they are due to atropine itself. Thus if "anticholinergic crisis" intervenes one might be prepared to use 2-4 mg. of physostigmine salicylate orally or intramuscularly to deal with it, and particularly with the accompanying respiratory depression.[35]

LSD and Other Hallucinogenic Drugs

There has been a general impression recently that the use of LSD has declined. It would probably be more accurate to say that its use has not continued to increase at the rate one might have expected some three to four years ago, and that its proponents have become less vocal. To some degree this change has been influenced by the controversy on the possible effects of the drug on genetic materials, a question which is still very much open and has by no means been settled.[36] It would be mistaken, nevertheless, to think that LSD is no longer used.

In an excellent review Unger[37] has pointed out that the effects of LSD, mescaline (the active principle of the peyote button) and psilocybin (derived from certain species of mushrooms)

are identical. Studies with radioactive isotopes have shown that they all disappear from the brain at the time the subjective experiences begin, and there is cross-tolerance between them. Presumably they work by triggering a common mechanism in the brain. Depending on the form in which they are taken, their effects will last a greater or lesser period of time, 8 to 12 hours being the commonly-accepted figure for LSD. The common elements of the drug experience are: a "saturnalia" or "orgy" of unique individual visual experience, a sense of alienation from the body or of depersonalization; and the view in retrospect of the drug experience that it has been an important or significant event in one's life.

This, of course, describes the experience when it goes well. The possible usefulness of these effects in treating certain psychiatric problems has not gone unnoticed, and is under active investigation.[38] It is possible that many amateur users of the drug are seeking a therapeutic effect as well, though for a variety of reasons they are unlikely to achieve it. When the hallucinogenic experience does *not* go well, one is faced with the infamous "bad trip." In spite of folklore to the contrary, such things as extensive prior LSD experience and the presence of sympathetic surroundings and a knowledgeable "guide" by no means guarantee that the "trip" will not be bad. It is not as yet possible to predict whether any trip in any individual, regardless of circumstances, will be "good" or "bad".[39] Therefore a "bad trip" is quite possible each time LSD is taken by anyone.

It is clear that the "badness" of a "bad trip" is psychological rather than physiological, at least with respect to the dangers to the individual. It has been described as "the crisis created in an individual when he perceives himself in a threatening situation following psychedelic drug usage" and has been termed "a toxic acute brain syndrome with disorientation and clouded consciousness"[35]— in other words, a delirium.[40] (Some authors, such as Unger, do not agree that LSD can cause a delirium, which raises the possibility that "bad trips" may be due to contaminants in illegally manufactured LSD.) It is interesting to note that the techniques employed by modern physicians in "talking down" the patient on a "bad trip,"[35] referred to by them under the general heading of "reduction of input overload," were extensively described by the great physician Soranus of Ephesus in the second century AD.[41] The Greeks, of course, did not have LSD, but the general treatment of acute confusional states has not changed from their day to ours. Chlorpromazine may, in this case, constitute a useful addition, if the means are at hand to protect against "anticholinergic crisis." It has also been suggested that other sedatives such as paraldehyde and barbiturates might be useful'[35] but this seems unlikely if the "bad trip" is indeed a delirium.

Soranus mentions the possibility of suicide in acute confusional states;[41] this has been reported with LSD in the psychiatric literature[42-43] as well as anecdotally. Contrary to an impression which may have been given, suicide has never occurred when LSD has been used therapeutically under adequate supervision.[28] The long-term effects of LSD abuse are a matter of some controversy.[44-47] There has been some evidence that it may lead to minimal brain damage.[48] Recently a rather ominous report has appeared of four young men with relatively good premorbid adjustment and no prior signs of psychopathology who developed intractible chronic psychosis after long-term psychotomimetic drug abuse.[49]

Volatile Solvents

Although the physician may be consulted by the parents of children who engage in the inhalation of the vapors of glue, gasoline, paint thinner, and other organic solvents, it is unlikely that he will be called on to treat the acute manifestations of this practice. The effects are short-lived, and the patient will either be over them or will be dead. In the past, most fatalities were due to suffocation; the substances were often inhaled from a plastic bag, which effectively strangled the user when he temporarily lost consciousness from the fumes. Interestingly, there was little evidence of serious, long-term

physical effects of this practice, probably because of the brief duration of exposure to the toxic substance.[50] With the recent increase in scope of the substances inhaled, sudden deaths unrelated to suffocation have been seen.[9] The suggested mechanism is a massive cardiac arrhythmia, brought on by a combination of hypoxia, hypercapnia, epinepherine sensitization of the myocardium due to preceding exercise, and sensitization of the myocardium by the halogenated hydrocarbons themselves. These deaths appear to be related to the use of trichloroethane, a constituent of spot removers, and to various flurocarbon propellants which are usually found in pressurized aerosol containers. In these cases there is no prospect of effective medical intervention.

Marihuana and other Cannabis Derivatives

Most of the furor about this class of substances has to do with its symbolic value for what has been called an emerging counterculture and very little to do with its effects as a drug. As there is little evidence on the safety of marihuana, there is reason for hesitation in making it more widely available by legalization. Even with the availability of laboratory tests, the difficulties with such drugs as thalidomide, chloramphenicol, and tobacco did not become apparent until, for many people, it was too late. The last thing needed by this country is another legal drug. Wikler[23] answers, definitively and succinctly, the argument which so frequently arises when this is said: "Is it not hypocritical to tolerate and advertise alcohol and prohibit marihuana? Yes, but it would be even more hypocritical for a government responsible for public health to tolerate both... The cure for hypocrisy is not more of it, but restoration of honesty, in this case by eschewing alcoholic intoxication as well as cannabis intoxication." As Dews[51] points out, cannabis derivatives have no positive use, and therefore the burden of proof lies with those who claim that cannabis is not harmful.

The prestigious *Medical Letter on Drugs and Therapeutics*, in its issue of April 17, 1970, succinctly summarized the psychological and physiological effects of cannabis preparations.[52] There is little likelihood that the general medical physician will be confronted with a cannabis user for treatment. If he is, reassurrance and mild sedation will suffice in virtually all instances. The kinds of adverse reactions to cannabis currently being seen have also been well summarized recently.[53] To Dr. Weil's list I would add my own strong clinical impression, supported by case reports in the literature[54-56], that marihuana, like LSD and amphetamine, can produce a prolonged psychotic reaction in individuals without a prior history of psychopathology. This is not surprising in view of the fact that tetrahydrocannabinol, the active principle of all cannabis preparations, can produce psychosis in all subjects if given in sufficient dosage.[57] Such cases are rare but require psychiatric attention.

Flashbacks

An uncommon but impressive phenomenon concerning which the physician may be consulted is the "flashback." This is the recurrence of the drug experience without the use of the drug. Most frequently associated with LSD use,[58] it has also been reported with marihuana and with STP.[59 60] To some users these recurrences are pleasurable but to many they are very frightening, as they signify a loss of control over the drug experience. No effective treatment is known nor is the cause of these experiences well understood. Users have assumed, probably correctly, that continued use of drugs would at least not diminish the probability that "flashbacks" would occur, and many have stopped using drugs for this reason. So intense is the panic that may be produced by a "flashback" that a psychiatric hospitalization is often necessary; suicidal wishes are often expressed in the desire to escape this peculiar consequence of drug use. Flashbacks will usually disappear spontaneously, though this may take a year to eighteen months.

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Long Term Management of Drug Abuse

When the acute problems associated with drug abuse have been dealt with, there remains the perplexing problem of what may be done so that the physician is not faced again in the immediate future with the same problem from the same drug in the same patient. To this problem there is no ready answer. Psychiatric care may be helpful in some cases. But it is not available to everyone, and in many instances it is not helpful. A number of treatment modalities which have been developed for narcotic addiction[60] may also be useful for the non-narcotic drug abuser. This is more true of such methods as the therapeutic community approach[61] than of the methods employing such drugs as methadone, cyclazocine and naloxone, which are specifically directed at opiate abuse.

The potential importance of the non-psychiatric physician in dealing with problems of drug abuse over the long term should not be underestimated. He may be particularly helpful if he has a good and pre-existing relationship with the drug abuser and, very importantly, with his family. In the context of our current culture, drug abuse cannot invariably be considered a manifestation of psychopathology, although that possibility is always present. Rather, in many in-

stances it represents a peer-group sanctioned, contemporary attempt of the abuser to find his way in this most difficult of all possible worlds. Among the many needs which such an abuser may have is that of an older and wiser person to show him the way. Lest this sound rather square, consider the speech of Kurt Schmoke, "the normally fire-breathing black secretary of the senior class" at Yale during the May Day disturbances there, as reported by *Time Magazine*, November 9, 1970, p. 86:

> The students on this campus are confused, they're frightened. They don't know what to think. You are older than we are, and more experienced. We want guidance from you, moral leadership. On behalf of my fellow students, I beg you to give it to us.

This is, it will be noted. not a request for something magical which only an old wizard like Shazam could confer on so romantic a figure as Captain Marvel. This is a request for something which physicians are eminently qualified to give: Their own humanity. □

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Long-Term observations:

Oxolinic Acid Treatment of Urinary Tract Infections

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OXOLINIC ACID is a synthetic quinoline derivative having bactericidal activity against nearly all gram-negative species except Pseudomonas.[1] Proteus and E. coli are exceptionally susceptible to the drug. It is related to nalidixic acid in structure (figure 1) but is more potent and has a somewhat wider antibacterial spectrum.[1]

A clinical study suggests that oxolinic acid may have less propensity to evoke resistant strains than does nalidixic acid.[2] In the clinical study cited, oxolinic acid was given, one gram twice daily for 14 days, to patients having chronic bacteriuria.

The present study was designed to extend the observations of oxolinic acid's clinical usefulness in terms of dose, duration of therapy, and duration of benefit to the patient. A slightly lower daily dose was given over a longer time to patients with acute, recurrent or chronic urinary tract infections. Further, many patients were followed for one year after therapy.

Thirty-five patients (twenty-six women and nine men) from a private practice population with acute, recurrent or chronic urinary tract infections were admitted to the study. Patients were admitted on the bases of having urine culture positive (greater than 10^5 organisms per ml) for gram-negative species and having standard symptoms of urinary tract infection (one exception). Ages ranged from 18 to 87 with a median of 55.

Thirty patients received tablets of oxolinic acid 750 mg b.i.d. and five patients received 1000 mg b.i.d. The original dose of 1 Gm. b.i.d. was lowered to 750 mg. b.i.d. when it became evident from animal and *in vitro* sensitivity studies that the smaller dose was adequate. The treatment period lasted for from 7 to 30 days, with a median of 28 days. Table 1 contains the diagnostic particulars of each patient.

Urine for culture was collected by having patients void after cleansing their genitalia with soap three times and then warm water. Mid-stream collections were obtained except for rare specimens which were obtained by catheter when the patient was too sick to provide a reliable voided specimen. Colony counts were performed on all specimens. Sensitivity to oxolinic acid was determined on all isolates using four disc strengths: 0.5, 1.0, 2.0, and 5.0 micrograms.

Colony counts were established by taking 0.01 ml calibrated loopfuls of fresh uncentrifuged urine and plating them on EMB and azide agars for the identification and quantitation of gram-negative and gram-positive organisms respectively. Plates were read (colonies x 100 = organisms/ml) after overnight incubation and representative colonies replated onto the indicated agar for the disc diffusion studies. These plates were read after 24 hour incubation. In the absence of firm criteria for zone of inhibition interpretation, any zone at all around any of the discs was taken to indicate sensitivity. In retrospect, this criterion was probably too loose to exclude organisms with only limited sensitivity to oxolinic acid.

Subsequent urine cultures were generally secured at the end of one, two, and four weeks of therapy. A patient was classified as a treatment failure if two consecutive urine cultures during treatment had greater than 10^5 viable bacteria/ml. Seventeen successfully treated patients were bacteriologically re-evaluated for three months post-therapy. Additionally, fourteen patients were followed for one year.

The following laboratory studies to evaluate the safety of oxolinic acid treatment were performed before and at the end of therapy; hemoglobin, hematocrit, WBC count, differential, BUN, SGOT, bilirubin, and alkaline phosphatase.

Results

Results on the two dose regimens were similar and will be considered together. Table 1 gives the detailed history of each patient.

Clinical improvement, indicated by partial or complete remission of symptoms, was noted in 29 (83 percent) of the 35 patients, 16 being cured and 13 improved.

Bacteriologically, 24 patients (69 percent) were cleared of their original pathogen at the end of treatment. Seven of these had significant super-infections (greater than 10^5 organisms/ml) arising during therapy. Three of the seven had gram-positive superinfections, and four had superin-

TABLE 1
PATIENT DIAGNOSTIC INFORMATION AND OUTCOME OF THERAPY

	PATIENT IDENTIFICATION			DIAGNOSTIC INFORMATION			RESPONSE TO THERAPY				
								BACTERIOLOGICAL RESPONSE			
	INI.	SEX	AGE	PRIMARY DX (STATUS OF INF.)	SECONDARY DX AND COMPLICATIONS	PRESENTING ORGANISM(S) AND DISC SENSI.	SYMPT. RESPONSE	PRESENTING ORGANISM	SUPERINFECTION DISC SENSI.	FOLLOW-UP TO 3 MO	FOLLOW-UP TO 1 Y
Oxolinic Acid: 750 mg b.i.d.											
	EH	M	82	Cystitis (A)	Ca bladder	E. coli-S	NI	E	Pseud sp-R	ND	ND
	BB	F	18	Cystitis (A)	Trichomonas vaginitis	E. coli-S	C	E	—	E	E
	AA	F	79	Cystitis (A)	Duodenal ulcer	E. coli-S	C	E	—	E	ND
	GS	M	44	Cystitis (A)	Pancreatitis	E. coli-S	C	E	—	E	E
	MR	F	50	Cystitis (A)	Diabetes	E. Coli-S	C	E	—	E	E
	RB	M	57	Cystitis (A)	—	E. Coli-?	I	E	Strep faec-R	ND	ND
	TM+	M	50	Urethritis Cystitis (A)	—	E. coli-S	C	E	—	E	E
	PH	F	69	Cystitis (A)	Diabetes	E. coli-S	I	P*	—	ND	ND
	DP	F	30	Cystitis (Re)	—	E. coli-S	C	E	—	E	E
	EF	M	60	Cystitis Prostatitis (Re)	—	E. coli-S	C	E	—	E	E
	CO'N	M	37	Cystitis (A)	—	Klebs-Aero-S	C	E	—	E	E
	SY	F	68	Cystitis (C)	—	E. coli-S	I	P*	—	ND	ND
	MS	F	72	Cystitis (C)	—	E. coli-S	I	P*	strep faec-R	ND	ND
	EM	F	71	Cystitis (C)	—	Klebs-Aero-S	I	P*	Proteus-R	ND	ND
	MZ	F	55	Cystitis (Re)	—	Klebs-Aero-S	NF	P	Strep faec-R	ND	ND
	CC	F	49	Cystitis (Re)	CVA	E. coli-? Pseud sp-?	NI	E	Proteus-R	ND	ND
	MP	F	69	Cystitis (Re) Pyelonephritis	Azotemia (BUN 60 mg)	E. coli-S	I	E	Proteus-R	ND	ND
	EE	F	30	Cystitis Pyelonephritis (A)	— —	E. coli-S	I	E	—	ND	ND
	GB	M	63	Cystitis Prostatitis (Re) Pyelonephritis	—	E. coli-S	I	P*	Klebs-Aero-R	ND	ND
	DA	F	22	Cystitis (Re) Pyelonephritis	Cholecystitis	Proteus-S	C	E	—	not available	E
	BT	F	27	Cystitis (Re) Pyelonephritis	—	Klebs-Aero-S	I	E	—	Reinf.	Reinf
	DS	F	51	Cystitis (A) Pyelonephritis	—	E. coli-S	C	E	—	E	E
	CS	F	22	Urethritis Cystitis (Re) Pyelonephritis	Congenitally abnormal urinary tract	E. coli-S	I	P*	—	ND	ND
	IB	F	69	Cystitis Pyelonephritis (Re)	Right hydronephrosis cystocoele	Paracolon-R	I	P	—	ND	ND
	OL	F	75	Pyelonephritis (Re)	Diabetes	Klebs-Aero-S	NI	P*	Strep faec-R	ND	ND
	RB	M	47	Pyelonephritis (A)	—	Pseud sp-S	NI	P*	—	ND	ND
	EH	F	28	Pyelonephritis (Re)	—	E. coli-S	C	E	Staph alb-R	E	ND
	PS	F	66	Pyelonephritis (A)	Ca sigmoid colon	Paracolon-S	C	E	—	E	E
	GD	M	47	Pyelonephritis (A)	—	E. coli-S	C	E	—	E	E
	AH	F	82	Asymptomatic bacteriuria (A)	—	Klebs-Aero-S	NI	E	E. coli-R	ND	ND
Oxolinic Acid: 1000 mg b.i.d.											
	MU	F	69	Hemorrhagic cystitis (A)	—	E. coli-S Strep faec-S	C	E	—	E	ND
	EE	F	61	Cystitis (Re)	Diabetes	E. coli-S	C	E	—	E	ND
	JH++	M	69	Cystitis (Re)	Prostatic hypertrophy	Pseud sp-R	NI	P	—	ND	ND
	MB	F	80	Cystitis (C)	Neurogenic bladder, Incontinence Indwelling catheter	E. coli-S	I	E	Strep faec-R	P (super)	P (supe
	LR	F	19	Pyelonephritis (A)	—	E. coli-S	C	E	—	E	E

Code: (A) Acute (Re) Recurrent (C) Chronic

fections due to gram-negative organisms.

Following therapy, of the 17 patients whose urine was recultured, 15 remained free of significant bacteriuria for 3 months, while 2 developed infections due to *Strep. faecalis*.

Of the 14 patients periodically rechecked for bacteriuria for one year, 12 maintained sterile urine while 2 required retreatment. These results ar summarized in Table 2 classified ac cording to whether the infection wa acute, recurrent or chronic.

Bacteriological results by organisr

TABLE 2: SUMMARY OF RESULTS OF OXOLINIC ACID THERAPY OVER TIME AS A FUNCTION OF STATUS OF INFECTION

Time		Acute U.T.I.	Recurrent U.T.I.	Chronic U.T.I.	
	No. in Group	17	14	4	
	Free of original pathogen at the end of therapy / 35 evaluated	15	8	1	24/35
up to 4 weeks	Free of significant bacteriuria* at the end of therapy / 35 evaluated	12	5	0	17/35
up to 3 months	Free of significant bacteriuria* at the last post-treatment culture / 17 evaluated	11	4	0	15/17
approx. 1 year	Free of significant bacteriuria* at the end of one year of observation+ / 14 evaluated	9	3	0	12/14

* $<10^5$ organisms/ml of urine
+ Cultures taken at 6 months and one year post-therapy

are shown in Table 3. The overall eradication rate was 27 of the 38 (71 percent) pretreatment organisms. The only species in sufficient quantity to consider separately was *E. coli* of which 20 strains (80 percent) were eradicated. One strain relapsed but was successfully eradicated in a second course of treatment. The eradication rate for superinfections during treatment was, as can be expected, considerably lower: seven of 20 organisms (35 percent). Two of the persisting presenting organisms and nine of the persisting superinfecting organisms were due to *Pseudomonas sp.* or to gram-positive organisms which are usually resistant to oxolinic acid.[1]

Ten of the 36 (28 percent) initially sensitive organisms developed resistance to oxolinic acid.

Side effects encountered during therapy are listed in Table 4. Eleven patients had a total of 30 reactions. Most of these side effects were first noted after 5 or 6 days of therapy. Reactions generally became more intense after 10-14 days. Most reactions were characteristic of CNS stimulation such as restlessness and hyperirritability, or of gastrointestinal involvement, e.g. nausea and abdominal cramps. Dose reduction to 375 mg b.i.d.—one-half table twice daily—was effective in controlling these effects in one patient. Another patient noted that antacids controlled the GI upset attedant on taking oxolinic acid. Three patients were discontinued from oxolinic acid because of side effects, while an additional 8 patients did not complete the planned 4-week course of therapy due to development of bacterial resistance to oxolinic acid.

Laboratory abnormalities unequi-

TABLE 3: BACTERIOLOGICAL RESPONSE BY ORGANISM

	Fate of Organisms Cultured From Pre-treatment Urine			Fate of Superinfecting Organisms Arising During Therapy		
	No.	Eradicated	Persisted	No.	Eradicated	Persisted
E. coli	25	20 (1)	(5)	1		1
Klebsiella-Aerobacter sp.	6	3	3 (2)	3	2	1
Pseudomonas sp.	3	1	2 (1)	1		1
Paracolon sp.	2	1	(1)			
Proteus sp.	1	1		2		2
Strep. faecalis	1	1		7	3	4
B Strep.				1	1	
Staph. albus				5	1	4
TOTALS	38†	27	11	20*	7	13
PERCENT		71	29		35	65

(No.) = developed resistance
* Six/twenty were in concentrations of less than 10^5/ml
† Thirty-six sensitive; two resistant

TABLE 4: ADVERSE REACTIONS

Drug Reactions:	No.
CNS	
Insomnia	1
Weakness	6
Restlessness	4
Dizziness	1
Headache	4
Anxiousness	1
Inability to concentrate	1
Photophobia	1
GI	
Nausea	8
Abdominal cramps	2
OTHER	
Palpitations	1
TOTAL REACTIONS	30
NO PTS. WITH REACTIONS	11 (31%)
TOTAL NO. OF PATIENTS	35

vocally due to oxolinic acid were *not* noted. One patient with azotemia (BUN = 60 mg%) was treated for 14 days with no change in renal status.

Discussion

Oxolinic acid was shown in this study to be reasonably effective in clearing the urine of susceptible pathogens. The four patients with chronic infections did not respond well to the drug, but they were too few to warrant generalization. Patients with acute and recurrent infections had a better response to oxolinic acid than did patients with chronic infections, although superinfection and development of resistance affected these patients to some extent.

In vitro studies of development of resistance to oxolinic acid[3] indicate that resistance can develop rapidly. This property of the drug underscores the need for carefully instructing patients not to miss doses, especially in the initial days of treatment when resistance is most likely to develop. The twice daily dosage should facilitate patient cooperation in this regard. Furthermore, to determine proper use of the drug, the need is obvious for culture and sensitivity testing both before and during therapy so that the physician is early made aware of initial sensitivity as well as of development of resistance or of the emergence of resistant superinfections.

As noted earlier, several organisms which were probably resistant to oxolinic acid were treated. Information regarding zone of inhibition relationship to MIC and achievable urine levels will greatly facilitate wise use of the drug.

The results of this study and of D'Alessio *et al.*[4] indicate that treatment with oxolinic acid should be continued for at least two weeks and possibly longer to lessen the chances of relapse or recurrence of infection.

The treatment regimen used in this study was convenient for patient and physician; there was no need to acidify or alkalinize the urine, and there was less potential for skipping doses on the twice daily regimen compared to a q.i.d. regimen.

Adverse reactions noted in this series were less frequent than in either of the clinical studies of oxolinic acid[2, 4] reported to date. Because these reactions generally appeared after a week or so of therapy, it was possible in one case to control them by dose reduction without a strong threat of resistance developing. Antacids may also be useful in this regard. When oxolinic acid was effective, the urine was generally sterile by the end of one week of therapy.

The long term follow-up of successfully treated patients was heartening. If the urine was sterilized by oxolinic acid therapy, relatively few patients had relapses or new infections for one year. This was true for patients with both acute and recurrent infections. Oxolinic acid appeared to be worthy of further trial in primary or recurrent urinary tract infection and may represent an improvement in the therapy of urinary tract infections.

Dr. Lampe is an internist in the renal clinic at York Hospital.

Summary

Thirty-five patients, most more than 50 years old, with acute, recurrent or chronic symptomatic urinary tract infections and with confirmed bacteriuria (greather than 10^5 organisms/ml) were treated with oxolinic acid tablets. Clinical improvement, indicated by partial or complete remission of symptoms, was noted in 29 (83 percent) of the patients. Twenty-four patients (69 percent) were cleared of their original urinary pathogens by the end of treatment. Seven of these 24 had significant superinfections by the end of treatment. Following therapy, of the 17 patients who were bacteriologically reevaluated for 3 months, 15 remained free of significant bacteriuria. Fourteen patients were followed for 1 year, and 12 remained free of bacteriuria.

Of the 38 pretreatment organisms, 27 (71 percent) were eradicated. Ten of the 36 initially sensitive organisms developed resistance to oxolinic acid.

Eleven patients had side effects; 3 of these discontinued medication because of their reactions. There were no laboratory abnormalities noted which were unequivocally due to oxolinic acid indicating safety from organic toxicity in the use of this drug.

The rate and duration of cures in this group of patients, many of whom had complicating factors or were previous treatment failures with other drugs, was encouraging. For patients infected with sensitive organisms, treatment for at least four weeks with oxolinic acid appears worthy of further clinical trial. □

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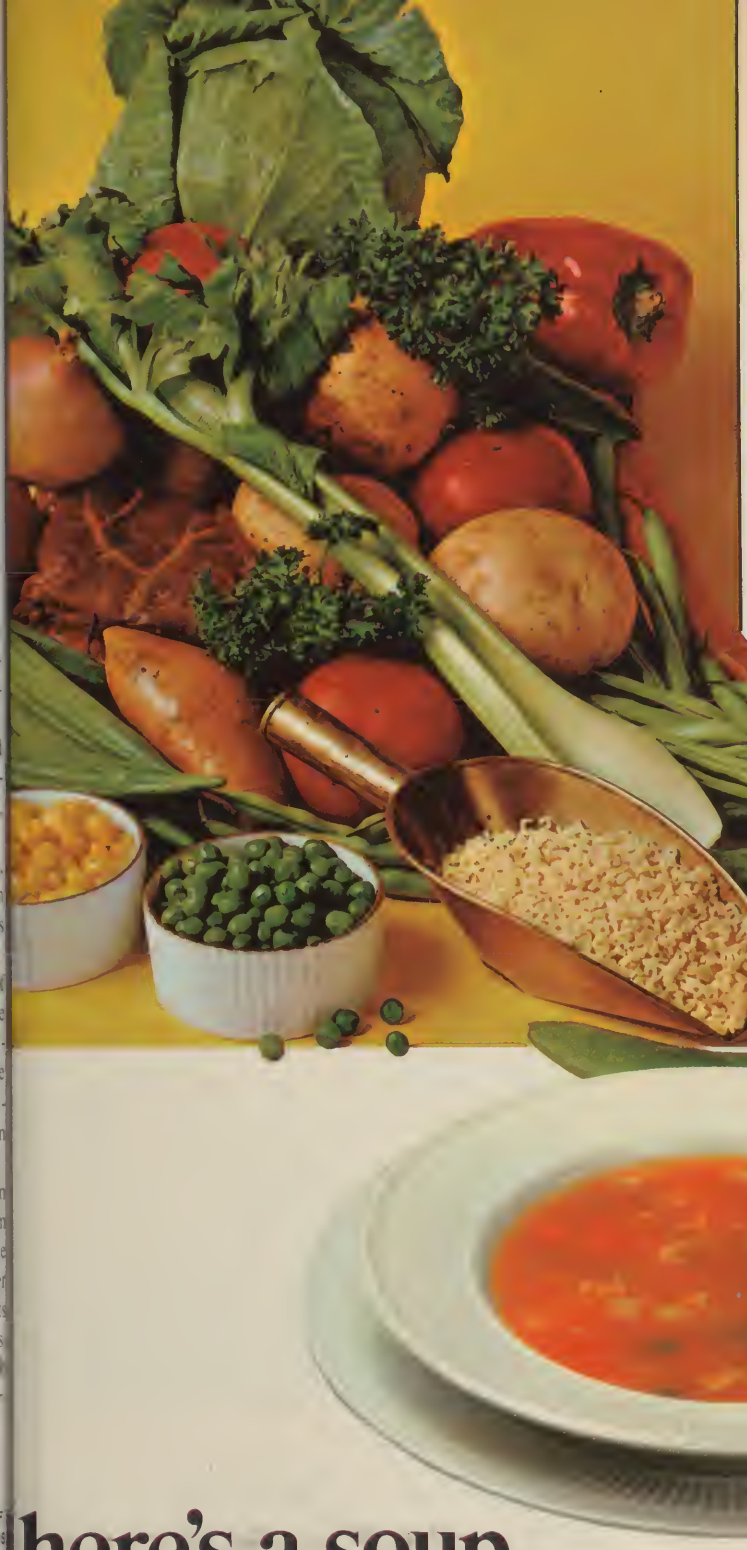

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A revealing picture of child abuse patterns is provided by one study of the American Humane Society. More than half of the 662 children involved (all reported in newspapers within a single year) were less than 4 years of age. One fourth of the battered youngsters died; most of these deaths were of children less than 2 years of age. Fathers were more often guilty of child abuse than mothers, but sometimes both parents participated. The study indicated that battered children are not limited to any particular socioeconomic stratum.

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Special note—Oral contraceptives have been marketed in the United States nce 1960. Reported pregnancy rates vary from product to product. The effectveness of the sequential products appears to be somewhat lower than that of he combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great ritain and the United States. Other risks, such as those of elevated blood ressure, liver disease and reduced tolerance to carbohydrates, have not been uantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of ome animal carcinomas. These data cannot be transposed directly to man. he possible carcinogenicity due to the estrogens can be neither affirmed nor efuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired iver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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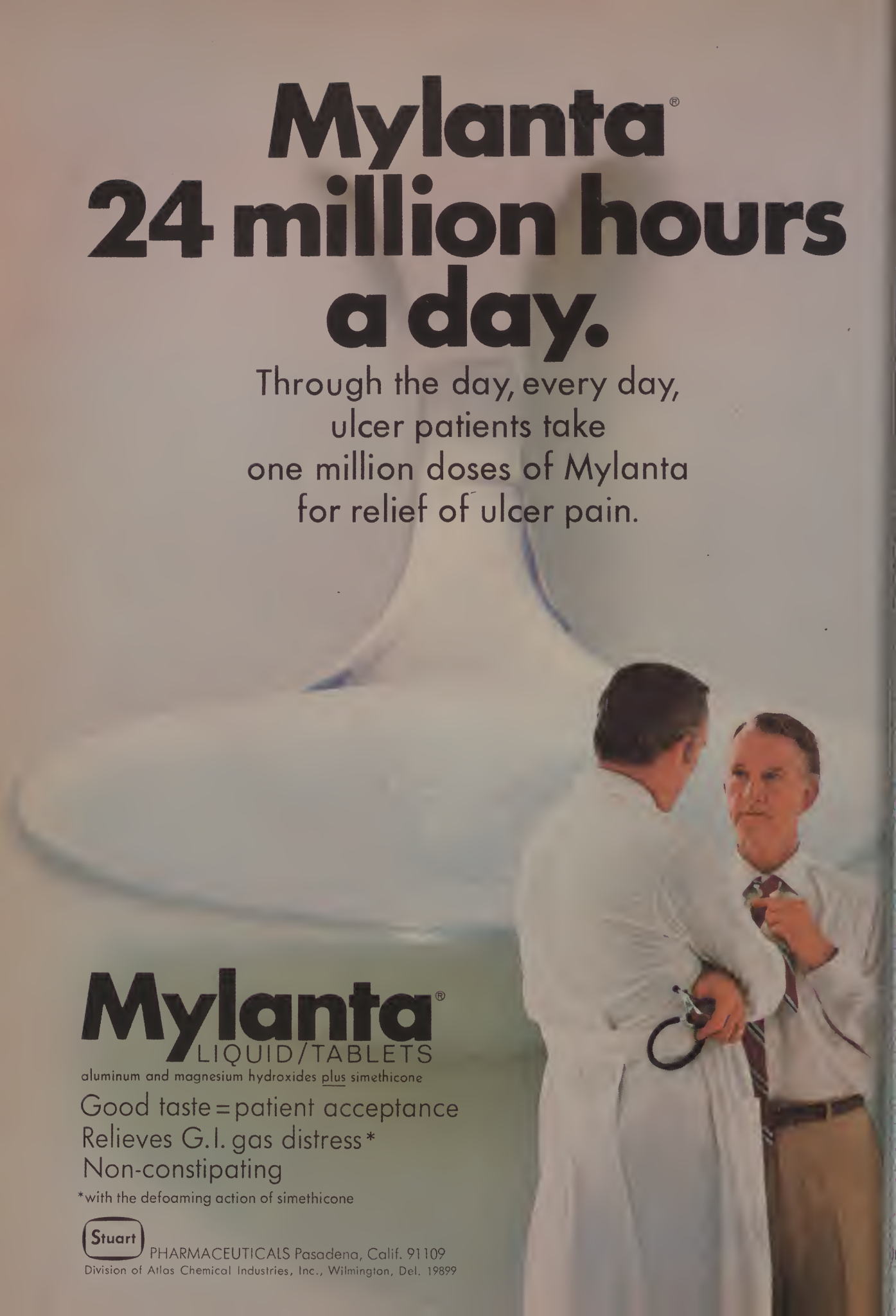

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Chronic Peritoneal Dialysis

NORMAN LASKER, M.D.
Philadelphia

CHRONIC peritoneal dialysis can maintain useful life in patients with chronic renal insufficiency, but only a few centers have had results comparable to those obtained with chronic hemodialysis.[1,2] This is partially due to the basic simplicity of the technique which allows it to be relegated to inadequately trained and supervised personnel and to a rather casual approach to a technique which is "eventually bound to fail." The general disillusionment with chronic peritoneal dialysis is not warranted since it can serve as a practical substitute for hemodialysis when the latter facilities are not available or overcrowded.

When compared to chronic hemodialysis, chronic peritoneal dialysis has several advantages. It does not require complicated or expensive equipment, the patient is free from the complications of an A-V shunt[3] and the trauma of fistula needles, there is less danger of hepatitis to patients and personnel,[4] and dialysis is performed through vital membranes. Despite a greater degree of

azotemia, the patient on peritoneal dialysis may do as well clinically as the patient on hemodialysis, suggesting that the peritoneal membrane may be relatively more permeable to unmeasured uremic toxins than cellophane or cuprophane.

Chronic peritoneal dialysis does have significant disadvantages and potential complications. Some of these are concerned with the means of gaining access to the peritoneal cavity. Intermittent peritoneal puncture with a seventeen French paracentesis trocar is too traumatic for chronic use, while permanent peritoneal prostheses usually results in peritonitis and adhesions.[5] [6] [7] A stylet catheter[8] makes catheter insertion less traumatic and when used at weekly intervals results in a low incidence of peritonitis and prolonged patient survival.[9] However, the use of the stylet catheter necessitates professional assistance for home dialysis, and repeated abdominal puncture eventually becomes a psychological burden for the patient. Jacob and Deane[10] have designed a peritoneal access button which is inserted into the peritoneal catheter's tract between dialyses to maintain its potency and eliminate multiple abdominal punctures. This device may be more successful than many more complicated prosthesis because it maintains a minimum amount of foreign material in the peritoneal cavity. All prosthetic materials permanently introduced into the peritoneal cavity increase the risk of adhesions and peritonitis.[11] However, silastic seems to be "one of the better tolerated materials."[2] A "permanent" silastic catheter which utilizes a dacron felt sleeve at the subcutaneous exit site has been used successfully by Tenckhoff.[12] The ingrowth of tissue into the dacron sleeve results in an excellent seal which prevents the peri-catheter access of bacteria into the peritoneal cavity. However, this prosthesis is most successful when used with a completely closed system of fluid delivery since the usual technique utilizing multiple bottles of commercial solution will eventually result in the introduction of a few bacteria into the peritoneal cavity which may not be successfully phagotyzed in the presence of a foreign body.[11]

Although the possibility of peritoneal contamination by the trans-intestinal movement of bacteria during peritoneal dialysis has been suggested[13] the majority of peritoneal infections in chronic peritoneal dialysis are due to staphylococcus aureus which probably enter through the catheter lumen or around the catheter.[14] Prophylactic antibiotics are not currently recommended as a routine procedure because of the probability of superinfection and the danger of drug accumulation and toxicity.[1] However, this complication can be virtually eliminated with a closed delivery and drainage system, the avoidance of permanent intraperitoneal devices, careful aseptic technique including the use of an antibiotic ointment around the catheter exit site, and the limitation of any single dialysis to approximately thirty hours.

Good nutrition is difficult to maintain in patients on chronic peritoneal dialysis. The patient is frequently anorexic during the procedure while he is losing protein, amino acids, and water soluble vitamins. Each litter of dialysis solution may remove 0.5 to 1.0 gm. of protein.[15] [16] Protein loss is enhanced by peritonitis and hypertonic solutions. Prolonging equilibration time will increase the protein concentration per liter.[16] Ascitic fluid may spontaneously accumulate between dialyses or result from previous episodes of peritonitis or chronic peritoneal irritation by an indwelling prosthesis. If the ascitic fluid is drained and not returned to the patient; it represents a large protein loss.[16] Amino acids are also lost in the dialysis fluid at a rate of approximately 0.1 to 0.3 grams per liter.[17] Folic acid is also lost[18] and these patients tend to have low folic acid levels in their blood without peripheral macrocytosis.[19] To compensate for the protein and amino acid losses, patients on chronic peritoneal dialysis require one g./kg. of high quality protein per day. If the patient develops peritonitis resulting in anorexia and increased protein loss, plasma or ascitic fluid may have to be infused I.V. to maintain N balance. Water soluble vitamins, particularly folic acid, should be given routinelv.

Dr. Lasker is an associate director of the division of nephrology at Jefferson Medical College and Hospital. He is also an associate professor of medicine and director of the dialysis unit.

Levin[20] has combined a modified Giordano-Giovanetti diet with infrequent dialysis in patients with "end-stage" renal disease. His patients are dialyzed every twenty one days which decreases their protein and amino acid losses. The diet provides approximately 0.5 g./kg. of protein per day, mainly in the form of high biological value electrodialyzed whey (lactalbumin), and a small amount of vegetable protein. Fifty to 75 calories per kg. per day are provided by diluting the lactalbumin with lactose, thin vegetable oils and dextri-maltose supplemented with fruit and vegetables. Similar results can be obtained with a modified Giovanetti diet utilizing egg protein and corn oil fat emulsion (Lipomul® Upjohn) instead of the lactalbumin mixture. However, due to the protein and amino acid losses of peritoneal dialysis and the difficulty patients have in following the fluid and dietetic restrictions imposed by infrequent dialysis, these patients go into negative N balance, become overhydrated, and after a few months require more frequent dialysis with a more liberal diet.

Another complication of chronic peritoneal dialysis is refractory hypertension which persists despite optimum salt and water balance. Vertes et al.[21] have suggested that such patients have elevated renin levels and will respond to bilateral nephrectomy. Gutkin et al. found low or normal renin levels in patients on chronic peri-

toneal dialysis. Renin activity increased following hypertonic eunatremic dialysis, but not after the use of isotonic hyponatremic solutions. Since acute dehydration is a potent stimulus to renin activity in these patients, hypertensive control should be improved by emphasizing fluid restriction during the week and utilizing nonhypertonic low sodium dialysis solutions.[22]

Several automatic systems have been developed to further simplify peritoneal dialysis, increase its efficiency and safety, and lower its cost. The simplest of these are the automatic cyclers which utilize commercial containers of dialysis solution (two or three liters), a series of valves to constrict the dialysis tubing at preset intervals, and gravity for peritoneal filling and drainage.[9] The connections to the multiple containers of dialysis solution are made at the beginning of the dialysis, and after each exchange the dialysate is collected into a large closed drainage bag or bottle. These cyclers retain the danger of introducing bacteria when making connections to the multiple containers and the cost of the sterile commercial solutions is relatively high. This cost factor restricts the volume of dialysis solution exchanged per hour to two to three liters, thereby limiting the peritoneal clearances.[23]

A closed automatic delivery and drainage system utilizing dialysis solutions mixed and autoclaved in forty-liter carboys in a hospital facility was developed by Boen.[24] Two liters of dialysis solution are pumped from the carboy into an elevated measuring bottle from which they are infused into the peritoneal cavity by gravity at preset intervals. Drainage into an empty carboy is performed by gravity with the assistance of a roller pump. The entire system is closed and the cost of the dialysis fluid is greatly reduced. The disadvantage of this system is the necessity of sterilizing the forty-liter carboys of solution in a large autoclave which limits its adaptability for home use. It requires a supply of distilled water and sterile glucose concentrate must be added after autoclaving to prevent its carmelization.

Roberts[25] has developed a flash sterilizer to simplify the hospital preparation of dialysis solutions without the danger of carmelization. It can prepare sterile dialysis solutions at the rate of one liter/minute, and also requires a source of distilled water.

Tenckhoff et al.[26] have recently developed a home peritoneal dialysis system which utilizes a small still to prepare pure water and a large pressure boiler to sterilize the mixed dialysis solution. Sorbitol is substituted for glucose to prevent carmelization. A roller pump is used to automatically fill the peritoneal cavity and drainage is by gravity. Approximately eighty liters are produced for each dialysis at a cost of approximately $13.00.*

An automatic peritoneal dialysis machine which mixes deionized tap water with a concentrate and pumps it in and out of the peritoneal cavity by a piston pump has been adapted for home use.[27] Before entering the peritoneal cavity the mixed solution is sterilized by passing through a 0.22 u millipore filter. The chief advantages of this closed system is the large volume of dialysate which can be exchanged per hour (approximately six to ten liters) and the low cost of the solutions. However, bacterial build-up on the filter can result in pyrogen reactions. Also it would appear that the basic simplicity of peritoneal dialysis is often offset by this relatively complicated and expensive machine.

Chronic hemodialysis is still the first choice for maintaining patients on chronic dialysis; but improvements in safety, efficiency, and cost of chronic peritoneal dialysis may place them on an equal status in the future.[28] Despite its present inferiority, peritoneal dialysis is capable of maintaining patients in a productive state if the safest dialysis techniques are combined with good medical management. □

* *Does not include cost of equipment.*

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Current Status:

PMS Continuing Education Requirements

TROUBLE KEEPING UP? Investigate the Physician Recognition Award of the American Medical Association

Courtesy of the Greene County (Missouri) Medical Society Bulletin

More and more questions are being received by the State Society about the continuing medical education requirements that are to become necessary for continued membership in PMS. There are two factors to keep in mind regarding the present status of the proposal. First, nothing will be official until after the 1971 House of Delegates takes action on the proposed amendments to the Constitution and Bylaws, which specify that only dues-paying classes of membership will be affected and that the first screening of membership will take place in the fall of 1975. Second, the requirements will be the same as those in effect for the AMA's Physician Recognition Award. At the present time an AMA "ad hoc" committee is making recommendations to the AMA Board of Trustees for expansion of some of these requirements, so it is possible that more types of education may be creditable by the 1973-74-75 qualifying period. The following data will give you the general background and requirements as they are at present.

. PRESENT STATUS

A. Approved by 1970 House of Delegates of PMS to ›ecome effective with the three-year qualifying period that tarts July 1, 1972 and ends June 30, 1975.

B. Committee on Constitution and By-laws has prepared he necessary amendments for Constitution and By-laws.

1. Action will be taken on these by the 1971 House of)elegates.

2. Classes of membership involved, dates for action, ıppeal mechanisms, and reinstatement procedures will be pecified therein.

I. REQUIREMENTS

A. Same as AMA's Physician Recognition Award equirements. (See attached guide.)

B. "Required" Credit Hours— 60 hours are required in :ach three-year period.

Category 4 is the one under which most members of ⁾ennsylvania Medical Society will, no doubt, report their ·equired credit. The AMA's definition of a course is "for he purpose of the Award, a course is considered to be a eries of educational procedures that are planned, coordiıated, and organized to meet specific educational objectives 'or a defined group of physicians."

Even though this lists only courses that are listed in JAMA, we have learned that unlisted courses may be reported if they are sponsored by an institution that is listed in the educational issue of JAMA. For example, if your hospital, medical society or medical college has one course listed in JAMA, all subsequent courses that year that are planned by that institution are eligible for credit in this category.

C. "Elective" Credit Hours— Balance of hours.

Category 7 allows up to 50 hours credit in any three-year period for attendance at local scientific programs i.e., staff meetings, medical society programs, etc.

Category 8 is the place to report the balance of the hours needed to complete the "elective" education. Recent interpretation from the AMA indicates that hours of attendance at management seminars may be reported by physicians in administrative positions. Of course, the more customary one-day scientific specialty programs will be the ones reported by most of the PMS members.

III. REPORTING

A. Each physician should keep a record of the number of hours that he attends courses, seminars, conferences, etc. (any scientific program).

B. Each physician completes his own AMA Award application and submits it directly to the AMA.

C. The AMA, at the end of the qualifying period in 1975, will supply the Pennsylvania Medical Society with a list of Pennsylvania physicians who have qualified for the Award. Those PMS members whose names do not appear on this list will be notified in accordance with the By-laws' provisions.

Note: The AMA has an ad hoc committee working on revisions for the present Award Requirements. These may, if approved by the AMA Board, include credit for any journals, taped instruction or video instruction that is secured as a part of a local hospital's continuing medical education program and also may include self-testing materials.

Requirements
Physicians Recognition Award

REQUIRED EDUCATION
(60 credit hours minimum)

1. AMA Approved Graduate Education
   (residency — internship — fellowship)
   each year equals 50 credit hours.
2. Education Leading to Advanced Degree in Medical Field
   each year equals 50 credit hours
3. Medical Research in lieu of residency training
   (must be full-time research)
   each year equals 50 credit hours
4. Continuing Medical Education Courses
   (any course listed in JAMA "Continuing Education Course for physicians")
   no limit toward 150 credit hours
5. Teaching (student contact)
   (Teaching of nurses and other allied health personnel not creditable)
   30 credit-hour limit
   excess — to 60 additional hours — may be credited as "elective")
6. Papers or Publications
   (Papers must be presented to organizations whose membership is limited to physicians. Publications must appear in recognized medical or scientific journals.)
   no limit toward 150 credit hours
   (10 credit-hour limit for each)

ELECTIVE EDUCATION

7. Scientific Medical Meetings
   Local (hospital staff meetings, medical society scientific programs)
   50 credit-hour limit
8. Scientific Medical Meetings — State, Regional, National and International
   (only attendance at scientific portion)
   50 credit-hour limit
9. Scientific Exhibits
   (credit cannot be given for exhibits shown only to local medical society or to non physicians groups)
   10 credit hours allowed for each exhibit
   30 credit-hour limit
10. Teaching (see 5 above)
    60 credit-hour limit

TOTAL ALL CATEGORIES: 150 hours minimum in any three-year qualifying period.

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Official Call to the 1971 Annual Session

PMS House of Delegates

The 1971 Annual Session of the House of Delegates of the Pennsylvania Medical Society will convene in Ballroom No. 1 of the Pittsburgh Hilton Hotel at 7:30 p.m., on Monday, October 4, 1971. The second and concluding meeting of the House of Delegates is scheduled for 9:00 a.m., Wednesday, October 6, 1971.

PROPOSED AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

Printed below is the text of the amendments to the Constitution and By-Laws which are being proposed by the Committee on Constitution and By-Laws.
Note: Material which is in italics is being added. Material which is enclosed in [brackets] is being deleted.

I. Subject: Change in the Composition and Qualifications of the Judicial Council in Response to Amended Resolution 70-1, the resolved portion of which is quoted below:

"RESOLVED, The Committee on Constitution and By-Laws be instructed to further investigate the advisability of increasing the number of members on the Judicial Council as well as changing the qualifications necessary for membership and that they bring to this House of Delegates at its next annual meeting an appropriate recommendation for the members of this House."

CONSTITUTION
ARTICLE IX -
THE JUDICIAL COUNCIL
Section 5 - Composition

"The Judicial Council shall consist of five members, qualified as provided in Section 6 of this Article IX, elected by the House of Delegates on nomination by the Board of Trustees and Councilors or from the floor of the House, for terms of [five years, so arranged that at each Annual Session the term of one member expires] *three years. At the time this amendment becomes effective, one member will be completing his first year, one his second year, one his third year, and one his fourth year of five year elected terms, and one member shall be completing his five-year term thereby creating a vacancy which shall be filled by electing one member for a term of three years, and in the case of the remaining four members, those members with two years and one year remaining of their five-year terms shall remain in office for a period of one year, at the end of which period such two positions shall be filled by electing two persons for terms of three years each; and those members with four and three years remaining of their five year terms shall remain in office for a period of two years, at the end of which period such two positions shall be filled by electing two members for terms of three years each. Thereafter, in the first year, one position will be filled for a term of three years; in the second year, two positions will be filled for periods of three years; and in the third year, two positions will be filled for periods of three years; and so forth thereafter.* At least thirty days prior to each Annual Session of the House of Delegates, the Board of Trustees and Councilors shall nominate at least three qualified persons for each vacancy on the Judicial Council and shall promptly publish their names to the membership of this Society in the Journal of this Society, if there be such, or by some other appropriate means; however, the failure of the Board to nominate any, or a sufficient number of, candidates or to publish their names shall not invalidate any election which is otherwise validly conducted by the House of Delegates. The Judicial Council annually shall select, at its first meeting, a Chairman and a Vice-Chairman who shall be members thereof. The Secretary of this Society shall serve as Secretary of *and alternate member* of the Council. *The Secretary shall become a voting member of the Judicial Council when any regular member thereof shall be unable to attend a meeting. In any event three members, including the alternate member, shall constitute a quorum, without which the Council can not properly conduct its business.*"

"Section 6. Qualifications of Members.

No member of this Society shall be eligible for election to the Judicial Council unless: (a) he has served as (i) a President of this Society; or (ii) a member of the Board of Trustees and Councilors for at least one full term; or (iii) a member of the House of Delegates for at least [ten] *five* years; and (b) he shall not be a member of a Component Society, a member of which (i) is then serving as a member of the Judicial Council and whose term will continue during any portion of the period for which the new member is to be elected, or (ii) has previously been

elected to the Judicial Council at the same election. Notwithstanding qualifications as set forth above, no person shall be eligible to serve for more than [two] *three* consecutive terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless he has served more than [two years] *one year,* and for this purpose a year shall be deemed to be the period between Annual Sessions of the House of Delegates."

II. Subject: Increased size and change in the procedure of the Committee to Nominate Delegates and Alternates to the AMA.

The 1970 House of Delegates: "Approved the recommendation of the Committee on Objectives that the Committee to Nominate Delegates and Alternates to the AMA be enlarged to include one representative from each Councilor District, and that the Committee be instructed to nominate more candidates than there are offices to be filled."

BY-LAWS - CHAPTER XIV -
COMMITTEES, ADMINISTRATIVE
COUNCILS, AND COMMISSIONS

Amend Section 2 - Standing Committees, Subsection (f) Committee to Nominate Delegates to the American Medical Association.

"[The Committee to Nominate Delegates and Alternates to the House of Delegates of the American Medical Association shall consist of three members, one member to be elected annually by the House of Delegates to serve for a term of three years. This Committee shall select its own chairman annually immediately upon the adjournment of the House of Delegates. It shall be the duty of this Committee to submit to the House of Delegates a list of nominees for delegates and alternates to the House of Delegates of the American Medical Association who are qualified under the requirements of the American Medical Association to hold such office.]"

(f) Committee to Nominate Delegates and Alternates to the American Medical Association. *The Committee to Nominate Delegates and Alternates to the AMA House of Delegates shall consist of fifteen members, composed of three members-at-large and one member from each of the twelve Councilor Districts. In the case of the three members-at-large, one is to be elected annually by the House of Delegates to serve for a term of three years. At the time this amendment becomes effective two members will be completing their first and second years and they shall complete same before such positions are subject to further election. In the case of the other twelve councilor district members, they shall be elected annually by the House of Delegates to serve for a period of one year. This Committee shall select its own chairman. It shall be the duty of this committee to submit to the House of Delegates a list of nominees for delegates and alternates to the House of the American Medical Association who are qualified under the requirements of the American Medical Association to hold such office. The list of nominees for both delegates and alternates shall include the names of more nominees than there are delegates and alternates to be elected.*

BY-LAWS
CHAPTER IV - ELECTIONS

"Section 5 - Nominations.

All candidates for any office to be elected by the House of Delegates may be nominated from the floor except that candidates for the Board of Trustees and Councilors *and the Committee to Nominate Delegates and Alternates to the AMA* shall be nominated only by a delegate from the nominee's Councilor District, *except that the three members-at-large of the Committee to Nominate Delegates and Alternates to the AMA may be nominated by any voting Delegate without regard to Councilor District.* No nomination shall be accepted by the House unless the delegate moving the nomination states that the nominee meets all of the qualifications prescribed by the Constitution and By-Laws for the office. In addition to nominations from the floor, (a) candidates for delegates and alternates to the American Medical Association may and should be nominated by the Committee provided for in Section 2 (f) of Chapter XIV of these By-Laws (b) a candidate for District Censor may and should be nominated by each Component Society, and (c) candidates for the Judicial Council may and should be nominated by the Board of Trustees and Councilors.'

III. Subject: Alternate Amendments to Increase the Size and Composition of the Committee to Nominate Delegates and Alternates to the AMA as proposed by the Committee on Constitution and By-Laws.

BY-LAWS
CHAPTER XIV - COMMITTEES,
ADMINISTRATIVE COUNCILS
AND COMMISSIONS

Section 2 - Standing Committees.

(f) *The Committee to Nominate Delegates and Alternates to the House of Delegates of the American Medical Association shall consist of five members with a term of three years except that at the time the amendment becomes effective two members shall be elected for one year, two shall be elected for two years, and one shall be elected for three years. The committee shall select its own chairman annually immediately upon the adjournment of the House of Delegates. It shall be the duty of this committee to submit to the House of Delegates a list of nominees for Delegates and Alternates to the House of Delegates of the American Medical Association who are qualified under the requirements of the American Medical Association to hold such office. In the discharge of this responsibility the committee shall formally requ*

commendations of nominees from each Component ociety. It shall further be required to publish its list nominees in the Official Call to the forthcoming ouse of Delegates meeting wherein the election is to held. Nothing in this section shall be construed as prohibit nominations from the floor. Service on the ommittee to Nominate Delegates and Alternates to e American Medical Association is limited to two rms.

IV. Subject: Reduction in the Size of the Committee on Objectives.

The 1970 House of Delegates took the following tion: "Referred to the Standing Committee on Constitution and By-Laws the recommendation that the ommittee on Objectives be reduced to seven embers."

BY-LAWS
CHAPTER XIV - COMMITTEES, ADMINISTRATIVE COUNCILS AND COMMISSIONS

Section 2 - Standing Committees.

"(g) Committee on Objectives.

[The Committee on Objectives shall consist of fifteen members, each with a term of three years, five appointed annually by the President of the Society; except that for the first year following the effective date of this paragraph the President shall appoint five members for a term of three years, five for a term of two years, and five for a term of one year. This committee shall select its own chairman. It shall be the duty of the committee to recommend objectives to the Board of Trustees and Councilors and to the House of Delegates, and to review annually these objectives and recommend any desirable changes.]"

(g) Committee on Objectives. *The Committee shall consist of seven members, each with a term of three years. When this amended paragraph becomes effective the committee shall be appointed and thereafter annually by the President of the Society; except that for the first year following the effective date of this paragraph the President shall appoint three members for a term of three years, two for a term of two years and two for a term of one year. This committee shall select its own chairman. It shall be the duty of the committee to recommend objectives to the Board of Trustees and Councilors and to review said objectives annually and to recommend any desirable changes. This committee shall also make an annual report to the House of Delegates.*

V. Subject: Alternate Revision of the Committee on Objectives as Proposed by the Committee on Constitution and By-Laws.

BY-LAWS
CHAPTER XIV - COMMITTEES, ADMINISTRATIVE COUNCILS AND COMMISSIONS

Section 2 - Standing Committees.

(g) Committee on Objectives. *The Committee on Objectives shall consist of seven members four of whom shall be members of the House of Delegates, appointed by the Speaker and three of whom shall be members of the Board of Trustees appointed by the Chairman. Among the appointees from the House shall be included one delegate who is either a member of SAMA, an Intern or a Resident. All appointments to this committee shall be made annually and become effective at the adjournment of the House. The Committee on Objectives shall report to the Board and shall submit annually a written report to the House of Delegates. This committee shall select its own chairman and vice-chairman. It shall be the duty of the committee to recommend objectives to the Board of Trustees and Councilors and to review annually these objectives and recommend any desirable changes.*

VI. Subject: Amendments to the Constitution and By-Laws to add a Continuing Education Requirement for Membership in the Society as mandated by the 1970 House of Delegates.

CONSTITUTION ARTICLE IV - MEMBERSHIP (Add a New Section 11)

Section 11 - Continuing Medical Education Requirement.

In order for an Active or Senior Active dues-paying Member of this Society to remain a member in good standing of the Society after December 31, 1975, he must show evidence of engaging in continuing medical education as prescribed by the By-Laws of this Society.

BY-LAWS CHAPTER I - MEMBERSHIP

Section 3 - Admission to Membership.

"Every member of a Component Society eligible to become an Active Member or a Senior Active Member of this Society shall become such upon receipt by the office of the Executive Director of the certification and assessment required by Section 4 of Chapter XVI of these By-laws. *The Continuing Education Requirement as provided in Section 5 of this Chapter I will not be invoked until the third year of membership.* Every member of a Component Society eligible to become an Associate Member of this Society shall become such upon receipt by the office of the Executive Director of the certification required by Section 4 of Chapter XVI of these By-Laws. Every member. . ."

(Add a New Section 5)

Section 5 - Continuing Medical Education Requirement.

In order for an Active or Senior Active dues-paying member of this Society to remain a member in good standing of the Society after December 31, 1975, he must have qualified for the American Medical Association's Physician Recognition Award,

which award is currently based upon a three-year continuing medical education program, which in this instance commences on July 1, 1972. Each Active or Senior Active dues-paying member once he has qualified for the American Medical Association's Physician Recognition Award, must continue to qualify for such award in order to remain a member in good standing of the Pennsylvania Medical Society. The Board of Trustees and Councilors shall, in accordance with procedures established by such Board, have the power to waive such requirements in those cases involving Active or Senior Active members of this Society serving temporarily in the Armed Forces or other Government service of the United States or prevented from the practice of medicine by reason of illness or disability or in such other cases as in its judgment such waiver should be granted.

"Section 6 - Suspension from Membership.

The membership of a member in this Society shall be suspended (a) *on December 31 of any year (beginning in 1975) if he is an Active or Senior Active dues-paying member who has failed to qualify for the American Medical Association's Physician Recognition Award provided the Office of the Executive Director has given such member sixty days notice prior to December 31 that such suspension will be invoked against him unless such member shall submit sufficient supplemental records to fulfill such award requirements by December 31, and such suspension shall be for a period of one year,* (b) upon suspension of his membership in his Component Society, and (c) upon the effective date, as provided in Section 7 of Chapter XIII of these By-Laws, of an order to that effect issued by the Judicial Council of this Society. The suspended member shall not be entitled to exercise any of the rights or privileges of membership during the period of suspension, shall be required to continue the payment of annual assessments without any reduction whatsoever, and shall be restored to full membership upon the expiration of the period of suspension *provided he has qualified for a current AMA Physician's Award Certificate.*"

"Section [5] *7* - Termination of Membership.

The membership of a member of this Society shall terminate (a) *in the case of Active or Senior Active Members suspended pursuant to subsection (a) of Section 6 of this Chapter who have not completed the continuing medical education requirement for the AMA Physician's Recognition Award by the end of the one year period of suspension, (b)* upon (i) termination of his membership in his Component Society for any reason whatsoever, or (ii) failure to pay a delinquent assessment within thirty days after notice of such delinquency as provided in Section 2 of Chapter IX of these By-laws, or (iii) three months after ceasing to be eligible for membership herein in the class of membership in which he is a member as specified in the Constitution, unless at such time an application or certification for another class of membership for which the member will become immediately eligible is pending in the office of the Executive Director of this Society, and ([b] *c*) upon the effective date, as provided in Section 7 of Chapter XIII of these By-Laws, of an order to that effect issued by the Judicial Council of this Society. Any person whose membership has been terminated for failure to pay a delinquent assessment shall be reinstated to membership without any break in continuity of membership upon payment of the delinquent assessment in full before December 31 of the assessment year, and reinstatement by his Component Society, but no such member under any circumstances shall be considered to be an Active, Senior Active, Intern or Resident member in good standing during the period between January 1 of the year for which assessment was delinquent and the date of reinstatement for the purposes of any section of the Constitution or these By-Laws. *Any Active or Senior Active dues-paying member whose membership has been terminated by reason of failure to meet the requirements for the AMA Physician's Recognition Award shall be reinstated to membership if, after meeting all the other requirements for reinstatement, he submits evidence that he has met the requirements for such award for current period and that at least one-third of the hours required were obtained during the current calendar year.*"

CHAPTER XVI - COMPONENT SOCIETIES

"Section 4 - Membership Records.

The Secretary of each Component Society shall keep a roster of its members in which shall be shown the full name, current address, [college] *medical or osteopathic school* and date of graduation, date of registration, and license to practice in this state, and such other information as may be necessary or appropriate. The Secretary of each Component Society shall note on such roster (a) any changes in membership, with appropriate dates, caused by changes in membership classification, death, resignation, transfer, *suspension, termination,* expulsion, or new admissions, and (b) changes of address, and shall promptly forward such information to the office of the Executive Director in appropriate form, which shall be on blanks, if any, supplied by this Society..."

VII. Subject: Amendments to the By-Laws to Change the Appeal Periods on Judicial Matters as Directed by the 1970 House of Delegates which:

"Directed that the Standing Committee on Constitution and By-laws prepare an amendment to the By-laws changing that section dealing with the Judicial Council so that the appeal period is extended from thirty (30) days to sixty (60) days." (Accomplishing the will of the House in this matter was contingent upon approval by the AMA House of Delegates of a resolution introduced by the Pennsylvan

elegation calling for extension of the AMA's appeal eriod from thirty (30) days to sixty (60) days.)

BY-LAWS

CHAPTER XIII - DISCIPLINARY PROCEEDINGS AND APPEALS

Section 4 - Appeals to District oards of Censors.

Any member of a Component Society who has en censured, suspended or expelled thereby, and ıy physician who has been refused membership by a omponent Society shall have the right of appeal to e District Board of Censors for that Councilor Dis- ict, provided that (a) written notice of the appeal is ven to the Councilor of the Councilor District ithin [thirty] *sixty* days after the censure, suspen- on, expulsion, or notice of rejection of an applica- on for membership, as the case may be, and in this tter connection the failure of a Component Society accept or reject an application for membership ithin six months after the filing thereof shall auto- atically be deemed to constitute a rejection at the id of said six months period, and (b) a brief, utlining the basis of such appeal, is presented to said ouncilor within ninety days after either of the events eretofore mentioned."

Section 5 - Appeals to the Judicial Council.

Any member of any Component Society or any omponent Society aggrieved by a decision of a Dis- ict Board of Censors may appeal from such decision y giving written notice of such appeal to the Judicial ouncil within [thirty] *sixty* days after the date of ıe decision of the District Board of Censors and by ubmitting a brief, outlining the basis of such appeal, the Judicial Council within ninety days after the ecision of the District Board of Censors. The action f the Judicial Council in cases of appeals shall be mited, except in extraordinary circumstances, to a eview of the record of the proceedings before the District Board of Censors."

Section 7 - Effective Date of Decisions f Component Societies, District Boards of Censors and the Judicial Council.

No action of any Component Society censuring, uspending, or expelling a member and no action of ny District Board of Censors affirming any such ac- ion shall become effective so long as the member has ny right of appeal under Sections 4 and 5 of this Chapter, or during the pendency of any such appeal. All decisions of the Judicial Council, whether in orig- nal proceedings or on appeals, shall become final pon the issuance thereof, except that any such ecision involving a member of the American Medi- al Association shall not become effective until thirty] *sixty* days after the decision of the Judicial Council, and, if the member or the Component Soci- ty, if any, has given written notice to the Judicial Council of the American Medical Association during said [thirty] *sixty* day period of his or its intention to appeal to that body and furnishes a copy of such notice to the Judicial Council of this Society, and, in the case of a member to the secretary of his Component Society, until the expiration of the appeal period and the final disposition of the appeal by the Judicial Council of the American Medical Association."

VIII. Subject: Clarification of Article XI of the Constitution regarding Active, Senior Active, Intern and Resident Members.

CONSTITUTION ARTICLE XI - FUNDS

"Section 1 - Annual Assessment.

Money for the purposes of the Society shall be raised by annual assessment payable by each Active, Senior Active, *Intern and Resident* member. [The assessment for Active and Senior Active Members shall be uniform except that the annual assessment for (a) Interns or Residents during their period of training shall be 10 per cent of the regular annual assessment,] *Senior Active Members shall be required to pay only 50 per cent of the annual assessment. Interns or Residents during their period of training shall be required to pay only 10 per cent of the annual assessment,* provided the Component Society, of which each is a member, grants a corresponding reduction in its annual assessment [,]. (b) *Members* serving temporarily in the Armed Forces or other Government service of the United States shall be excused for any assessment year in which the member enters service prior to March 1, is in service for the entire assessment year, or returns from service on or after March 1. [and] (c) *Any member* prevented from the practice of medicine by reason of illness or disability shall be excused, provided the Component Society of which each is a member grants a corresponding exemption from its annual assessment. No annual assessment shall be payable by an Associate, Affiliate, Special Student or Honorary Member..."

IX. Subject: Clarification of Intern and Resident Membership Category.

CONSTITUTION ARTICLE IV - MEMBERSHIP

"Section 6 - Intern and Resident Members.

Intern and Resident Members shall be persons serving an *accredited hospital* internship, [or a] residency, *or other form of recognized full-time postgraduate training.* [in an accredited hospital in Pennsylvania.], Intern and Resident members shall be required to pay 10 per cent of the annual assessment."

X. Subject: Technical Correction of the By-Laws Dealing with the Six-Year Term Limit on Members of Councils, Commissions and Committees.

BY-LAWS

CHAPTER XIV - COMMITTEES, ADMINISTRATIVE COUNCILS AND COMMISSIONS

Section 1 - Appointment of Members, Vacancies and Qualification.

(d) Qualification for Membership on Committees, Administrative Councils and Commissions.

"(iv) No member of *a committee,* an administrative council, or a commission shall serve more than six consecutive terms. For the purposes of this subsection, a member appointed to fill a term or unexpired term of less than one-half the regular term of that appointment shall not be deemed to have served a term."

XI. Subject: Change in Name of the "Advisory Committee to the Executive Director" to the "Executive Committee."

BY-LAWS

CHAPTER V - BOARD OF TRUSTEES AND COUNCILORS

"Section 3 - Committees of the Board.

The Board shall have the following standing committees consisting of three or more members:

(a) Finance Committee

(b) Publication Committee, to supervise the publication of the JOURNAL.

(c) [Advisory Committee to the Executive Director.] *Executive Committee. The Executive Committee shall have only that authority given it by the Board.*

ELECTIONS

Among the general officers to be elected by the 1971 House of Delegates will be:

A President-Elect, four Vice-Presidents, a Secretary, a Speaker of the House of Delegates, and a Vice-Speaker of the House of Delegates.

A Trustee and Councilor for the Second Councilor District, to serve for five years to succeed Leroy A. Gehris, M.D., Berks County, who is eligible for re-election, having served two years of the unexpired term of William A. Limberger, M.D., Chester County.

A Trustee and Councilor for the Eighth Councilor District, to serve for five years, to succeed David J. Keck, M.D., Erie County, who is eligible for re-election having served two years of the unexpired term of James Biggins, M.D., Mercer County.

A Trustee and Councilor for the Eleventh Councilor District, to serve for five years to succeed William C. Ryan, M.D., Somerset County, who is eligible for re-election having served one year of the unexpire term of D. George Bloom, M.D., Cambria County.

Also to be elected for a two-year term beginnin January 1, 1972 will be five delegates and five alte nate delegates to the American Medical Association.

Delegates whose terms expire December 31, 197 are:

Wendell B. Gordon, M.D.
Samuel B. Haddon, M.D.
John B. Lovette, M.D.
Thomas W. McCreary, M.D.
(retired, January 1971)
Malcolm W. Miller, M.D.
Russell B. Roth, M.D.

Alternates whose terms expire December 31, 19 are:

Robert F. Beckley, M.D.
Wilbur E. Flannery, M.D.
Paul S. Friedman, M.D.
Matthew Marshall, Jr., M.D.
David S. Masland, M.D.

Also to be elected will be a member to serve f three years on the Committee to Nominate Delega and Alternates to the American Medical Associati to succeed Edgar W. Meiser, M.D., Lancas County, whose term expires and who is eligible succeed himself.

Also to be elected will be one member of t Judicial Council to serve for a term of five years succeed Lewis T. Buckman, M.D., Luzerne Coun who is eligible to succeed himself. As directed by A ticle IX Section 5 of the Constitution, the Board Trustees nominates the following members for t vacancy on the Judicial Council: Lewis T. Buckm M.D., Luzerne; Charles A. Bikle, M.D., Franklin a a third physician to be nominated by the Board at August meeting to take the place of Clarence J. M Cullough, M.D., Washington, who died on June 1971. The name of the third nominee will published in the September issue of PENNSYLVA MEDICINE.

Also to be elected is a District Censor from ea Component County Medical Society to serve for e year following the close of the 1971 House of De gates session.

The Component County Medical Societies h submitted the following nominations for Distr Censor:

Adams, James H. Allison; Allegheny, Robert Schein; Armstrong, Arthur R. Wilson; Beav Herman Bush; Bedford, William E. Palin; Ber Eugene Mendelsohn; Blair, John W. Hurst; Bradfo Willis A. Redding; Bucks, Stanley F. Peters; Butl Robert C. McCorry; Cambria, Warren F. Whi Carbon, James M. Steele; Centre, H. Richard Ishl Chester, Grant W. Bamberger; Clarion, Theodore Koenig; Clearfield, Fred Pease; Clinton, George Treires; Columbia, James F. Youngkin; Crawfo

obert L. Kirkpatrick; Cumberland, Hans S. Roe; auphin, Nathan Sussman; Delaware, Richard H. landreau; Elk-Cameron, James L. Hackett, Sr.; Erie, obert L. Loeb; Fayette, Harold L. Wilt; Franklin, lbert W. Freeman; Greene, William W. Barthol- new; Huntingdon, Thomas S. Mainzer; Indiana, arold L. Edison; Jefferson, Franklin S. Bizousky; ackawanna, Joseph J. O'Brien; Lancaster, Charles . Kurtz; Lawrence, Gerald H. Weiner; Lebanon, C. ay Bell; Lehigh, Frederick R. Bausch, Jr.; Luzerne, onald F. Closterman; Lycoming, Wilfred W. Vilcox; McKean, Ralph E. Hockenberry; Mercer, obert E. Sass; Mifflin-Juniata, John R.W. Hunter, .; Monroe, Claus G. Jordan; Montgomery, Rudolph . Glocker; Montour, Isaac L. Messmore; lorthampton, Walter J. Filipek; Northumberland, icholas Spock; Perry, Frank A. Belmont; hiladelphia, Charles M. Thompson; Potter, Herman . Mosch; Schuylkill, Joseph T. Marconis; Somerset, lexander Solosko; Susquehanna, Raymond C. avis; Tioga, Ivan T. Brechbill; Union, John S. Pur- ell, Sr.; Venango, Frank Esparraguera; Warren, onald J. Furman; Washington, Herbert J. Levin; Vayne-Pike, Howard R. Patton; Westmoreland, eslie S. Pierce; Wyoming, John S. Rinehimer, Jr.; ork, William C. Langston.

XII. Subject: Restructuring of the Medical Defense und. These amendments are prepared at the direc- on of the Board of Trustees as a result of action ıken at its meeting, May 12, 1971 and detailed in its nnual Report.

BY-LAWS
CHAPTER I - MEMBERSHIP

ection Four - Limitations on
rivileges of Membership.

In addition to the limitations on the rights and rivileges of membership contained in the Constitu- on of this Society and elsewhere in these By-laws, either [Associate, Affiliate members nor special tudent, unless expressly authorized in these by-laws, hall be entitled to the benefits of any Medical Defense or similar fund established by this Society, nd Affiliate Members and] *Affiliate Members or* pecial Student Members shall [not] be entitled to he benefits of any Medical Benevolence or similar und established by this Society.

CHAPTER V - BOARD OF TRUSTEES AND COUNCILORS

ection 1 - Duties.

In addition to the duties set forth in the Constitu- ion and other sections of the By-laws of this Society, he Board of Trustees and Councilors shall exercise eneral supervision over the conduct of all adminis- rative councils and committees in the interval be- ween Annual Sessions; it shall have the right to orrow money on behalf of this Society, and to invest its funds; it shall have charge of all the properties of the Society with authority to purchase, mortgage, lease, sell, or otherwise dispose of any real estate; ... it shall appoint substitute delegates and substitute alternates to the House of Delegates of the American Medical Association when permitted to do so by the By-laws of the American Medical Association; *it shall have the authority to expend monies of the Society to defray legal expenses associated with the defense of individual members, groups of members or county societies in any case where it believes the best interests of a substantial number of members are so served;* and it shall render a report at each Annual Session of the House of Delegates.

CHAPTER VIII - LEGAL COUNSEL

Section 2 - Duties.

Legal Counsel of this Society shall advise the House of Delegates, the Board of Trustees and Councilors, the Judicial Council, the committees, administrative councils and commissions, and the staff with respect to legal matters. All referrals of matters to legal counsel by committees, administrative councils, commissions and the staff shall first have the approval of the Executive Director in accordance with such discretionary authority as may be granted to him from time to time by the Board of Trustees and Councilors.

[All suits for alleged malpractice brought against Members of this Society for which application to the Medical Defense Fund has been or may be made shall be immediately reported to legal counsel, and he shall be asked to endorse local counsel suggested by the Trustee and Councilor for the Councilor District to defend such suits. All suits of any nature against a Component Society shall be immediately reported to legal counsel. All proposed appeals in suits for which the expenses are being paid by the Medical Defense Fund and all appeals in all cases against component societies of any nature whatsoever, shall be first submitted to legal counsel of the Society for approval and for suggestions.]

CHAPTER IX - ASSESSMENTS AND FUNDS

Section 3 - Deposit of Monies
in Special Funds.

The Executive Director shall deposit all monies of the Society received by him in such bank accounts as the Treasurer shall direct and it shall be in accord with the provisions of Section 6 of Chapter VI of these By-Laws.

Monies constituting [the Medical Defense Fund and] the Medical Benevolence Fund shall be kept segregated in *a* separate account[s] and may be invested by the Treasurer under the direction of the Board of Trustees and Councilors."

Section 6 - [Medical Defense Fund.

Each year out of the funds of this Society the

Board of Trustees and Councilors may appropriate a sum not to exceed $1.00 for each Active Member and Senior Active Member to be set aside by the Treasurer as a special fund to be known as the Medical Defense Fund.

The fund shall be used only for the expenses, as hereinafter defined, of (a) Members or the estates of physicians who were members at the time of death threatened with suit or sued for alleged malpractice committed while an Active or Senior Active Member and while the member was in resident practice in Pennsylvania, provided such member is not believed by the Committee of Counsel to be guilty of criminal abortion, feticide, homicide, any criminal act, or of failing to conform to recognized ethical principles in relation to the case, and provided further, that the case arises in connection with the course of the care and treatment of patients as a physician, and (b) any group of Active Members or any Component Society threatened with suit or sued in a matter involving the professional standing or conduct of such members or Component Society or the standards of the profession of medicine, when approved as to this clause (b) by the Board of Trustees and Councilors. Expenses shall include all reasonable expenses necessary to a proper defense of the case except expenses for serving subpoenas, expenses of witnesses residing within the country and any judgment or fine awarded or imposed by the jury or court.

The Medical Defense Fund shall be administered by the Secretary of this Society, who shall certify to the Treasurer all amounts to be paid from the Fund.

When a member is sued or threatened with suit and wishes to apply for medical defense he shall so notify the Trustee and Councilor for his Councilor District and shall request an application form from the Secretary of the Society. If the member wishes that his own attorney be retained, he shall so advise his Trustee and Councilor and the Secretary, giving the attorney's name and address. He shall then (a) fill out and sign the application; (b) have it endorsed by the unanimous vote of those censors of his component society who are present at a special meeting called for the consideration thereof, providing a quorum is present; (c) secure the approval of it by his Trustee and Councilor; and (d) file it with all necessary approvals and endorsements in the office of the Secretary of this Society, at any time prior to suit, or within sixty days after service of summons. The Secretary shall submit the application to the President for approval and promptly notify the applicant of the action taken.

If the member has insurance which provides a defense to the suit, no further action need be taken with respect to his application.

If the member does not have such insurance or if there is a question as to coverage:

(a) An attorney may be retained on his behalf by his Trustee and Councilor at any time prior or subsequent to suit, pending approval or disapproval of his application for medical defense, provided that (i) the attorney is approved by Legal Counsel for the Society, and (ii) the Executive Director of this Socie certifies that the member was an Active or Senior A tive Member in good standing at the time of th alleged malpractice and a member in good standing the time the attorney is being retained. The Secreta may certify the payment of necessary court costs ar fees for the service of such an attorney if the amou thereof has been approved by Legal Counsel of th Society.

(b) After approval of the member's application ar determination that he has no insurance providing defense to the action (or in cases of dispute as to co erage, pending such determination), the Committee Counsel, composed as set forth in Section 2(c) Chapter XIV of these By-laws, shall manage h defense. The Committee shall retain legal counsel fo the member with the approval of Legal Counsel fo the Society and take such other steps as it deems ne essary to provide the member with an adequa defense and to obtain early disposition of the case c a basis equitable to the claimant and the member. Th members of the Committee of Counsel shall be pai from the Medical Defense Fund for their time ex pended and for their necessary expenses. The Secre tary may certify payments from the Medical Defens Fund for expenses in connection with such defense o the following conditions: (i) the Committee Counsel has approved the expense; (ii) no part of th expense is for services required to be furnished to member by any insurance company under a policy malpractice or other similar insurance; and (iii) th amount of counsel fees has been approved by Lega Counsel for the Society. With the specific approval the Board of Trustees and Councilors, the Secretar may certify payments which do not meet the abov conditions.

The application for medical defense shall contain contract signed by the member giving the Committe of Counsel sole authority to conduct the defense c his suit.

The approval of any application for medica defense by the Trustee and Councilor and by th Censors of the Component Society carries with it no only their moral support but their willingness to ac tively participate in the conduct of the trial in an way they may best assist and all without thought c pecuniary return.

Any group of Active and/or Senior Activ Members or any Component Society sued or threat ened with a suit, the expenses of which can be pai from the Medical Defense Fund, may apply in writin to the Board of Trustees and Councilors for th payment of such expenses and for legal assistance an advice, but no such application will be considered b the Board with respect to expenses already incurred.]

Secretary's Note: Old Section 7, Medical Benevolence Fund becomes new Section 6. Old Section 8, Educational Fund becomes new Section 7.

CHAPTER XIV - COMMITTEES, ADMINISTRATIVE COUNCILS AND COMMISSIONS

ection 2 - Standing Committees.

This Society shall have the following standing committees:

Advisory Committee to the Woman's Auxiliary
Committee on Constitution and By-laws
[Committee of Counsel]
Committee on Medical Benevolence
Committee on Aid to Education
Committee to Nominate Delegates to the American Medical Association
Committee on Objectives
Committee on Relationships with Allied Professions
Committee on Discipline

CHAPTER XVI - COMPONENT SOCIETIES

Section 11 - Litigation Reports.

The secretary of each Component Society shall immediately report to the Secretary of this Society all suits for alleged malpractice brought against members of the Component Society for which application to the Medical Defense Fund has been or may be made. Such report shall include the names of the parties, the names of the similar reports of all suits of any nature filed against their respective Component Societies.]

Standing committees shall submit annually a written report to the House of Delegates to be delivered to the office of the Executive Director before July 1, and shall be composed and have the functions, as follows:...

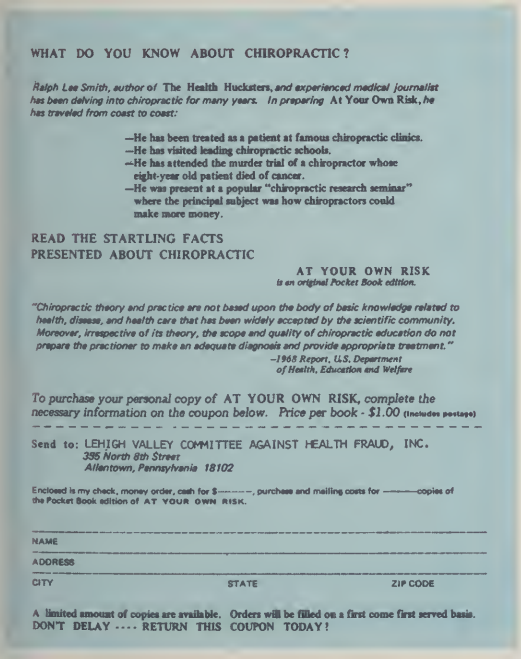
(c) [Committee of Counsel. The Committee of Counsel shall consist of the President and the Secretary of this Society who shall be the chairman thereof and in addition, when acting on medical defense cases, the Trustee and Councilor for the Councilor District of the member involved and the attorney or attorneys engaged to handle the case. This committee shall perform the functions prescribed in Section 6 of Chapter IX of these By-laws.]

Secretary's Note: Old Subsection (d), Committee on Medical Benevolence, becomes new Subsection (c). Old Subsection (e), Committee on Aid to Education becomes new Subsection (d). Old Subsection (f), Committee to Nominate Delegates to the American Medical Association becomes new Subsection (e). Old Subsection (g), Committee on Objectives becomes new Subsection (f). Old Subsection (h), Committee on Relationships with Allied Professions, becomes new Subsection (g). Old Subsection (i), Committee on Discipline, becomes new Subsection (h).

This Call of the Annual Session of the House of Delegates has been issued this first day of July, 1971.

Raymond C. Grandon, M.D.,
Secretary

Help the fight against chiropractic, health fraud



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—He has visited leading chiropractic schools.
—He has attended the murder trial of a chiropractor whose eight-year old patient died of cancer.
—He was present at a popular "chiropractic research seminar" where the principal subject was how chiropractors could make more money.

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'Let George say it'

The FDA and physicians

GEORGE A. ROWLAND, M.D.
Millville

The Food and Drug Administration is regularizing the pharmacopoeia. Inexorably, the noose of federal restriction is tightening about the neck of every physician. So insidiously has this been carried out that practically no objection has been raised. Even a trustee of the AMA has agreed that it is right to drop drug combinations that are "probably not effective."

While doctors have given most of their attention to government medical insurance plans, this program has been moving forward quietly. Committees of experts have been set up to evaluate drugs. Who names the experts is not explained, nor how their fields of expertise are applied, but it appears that they are well-regarded physicians who seriously consider their tasts.

The tasks are even less clear. Apparently, currently marketed pharmaceuticals are evaluated as— effective, probably effective, possibly effective, probably not effective, and not effective. It is a subjective evaluation that places an item in one category rather than another. It is easy to see that one man would weigh one end of such a scale heavier than would another.

The next step is more interesting. Evaluations of medical experts are turned over to bureaucrats. Suddenly there is a recommendation that "X" medicine, being doubtfully effective should be "not approved."

The sad part about this is that "not approved" has the same effect as interdiction. Drugs on this list will be forever beyond the doctor's reach.

Today we see old familiar combination medicines outlawed. The succession follows inevitably. As the world of medicine accepts one inroad, the next is driven a little deeper. The antibiotics will be winnowed away. Perhaps we will be left with one penicillin, one tetracycline. Some great allergist's favorite antihistamine will survive alone. One steroid will be enough. The TV battles of the pain killers will be no more when the directive wipes out all but aspirin.

Soon even the names will be dropped. Since all allowable drugs will be part of the official formulary, only a number will be needed on a prescription. It will do no good to write for anything else. It would be illegal and in any event unavailable.

The ghost of Dr. Humphrey, the homeopathic patent medicine king, is chuckling over us. Soon all the triumphant therapeutic achievements of American medicine will be cut down to numereed items in a federal registry.

Because doctors do not like to make a fuss and because some of these drugs really may not be very good, American medicine lies back and suffers a mortal ravishing. If this runs scores, medicine and American civilization will have lost a major baseball game.

AMA counsels doctors on VD situation

The problems of VD are many: Permissiveness, limited staffs in public health departments, insufficient funds, reluctance on the part of the public about the dimensions of VD, prevention and treatment. The medical profession has a significant role in reducing the growing incidence of VD.

In view of the alarming increase in reported cases of infectious syphilis and because gonorrhea is now pandemic in the United States, the Council of Environmental and Public Health of the AMA has issued the following statement:

"The American Medical Association Council on Environmental and Public Health reports that gonorrhea ranks first and syphilis third among the reportable communicable diseases in the United States. For the year ending June 30, 1970, infectious syphilis rates were 8 percent higher nationally than a year earlier, with annual increases spread over 33 states and an estimated incidence between 70-80,000 reported cases; there are 250,000 cases of all forms of syphilis estimated to be diagnosed and treated each year.

"At the same time, gonorrhea morbidity exceeded 573,000 reported cases. Gonorrhea is pandemic in the United States, with an estimated two million cases.

"The council urges medical societies to acquaint their membership with the growing and alarming dimension of the VD problem. Physicians should take all appropriate measures to reverse the rise in venereal disease and bring it under control.

"Physicians in private practice treat approximately 8 percent of the syphilis and gonorrhea that comes to diagnosis but report to public health departments only one out of every eight cases of syphilis and one out of every nine cases of gonorrhea they treat. Physicians should assist public health departments by reporting the VD cases they treat. Medical societies are urged to cooperate and give broad support to public health authorities. Much effort must still be made by health departments and medical societies to foster mutual trust so that public and private medicine can work effectively for the control of both syphilis and gonorrhea.

"The council also urges medical societies to continue efforts for the enactment of state laws to permit physicians legally to treat VD cases of minors without obtaining parental consent. Currently, thirty-five states have laws and six states have opinions of attorneys general permitting treatment of minors for VD without permission of parents. Such sanction is not provided in the states of Alabama, Arizona, Georgia, Mississippi, Minnesota, Missouri, Ohio, Wisconsin and Wyoming.

"The American Medical Association is making VD a national theme for Community Health Week— 1971, with suggested dates of October 17-23. Informational and promotional material will be available for medical societies."

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Chronic Obstructive Pulmonary Disease (C.O.L.D.) and the Heart

Part II

Harry Shubin, M.D., F.C.C.P., Medical Director and Administrator of Center City Hospital, Philadelphia, Pennsylvania, is questioned by William G. Leaman, Jr., M.D.

Thus far, you have not discussed the cardiac picture. Why?

This was delayed purposely, since with early diagnosis and active, continued therapy, the development of heart disease could be prevented or delayed. Untreated, advanced chronic obstructive pulmonary disease patients develop cor pulmonale or right ventricular dilatation and/or hypertrophy, with or without cardiac failure. Hypoxia and hypercapnia cause elevation of pulmonary artery pressure through vaso-constriction, with pulmonary hypertension. When the heart is no longer able to compensate for the increased work load, the diastolic pressure in the right ventricle rises, the venous pressure increases, the circulation time becomes prolonged, and renal function is impaired. As heart failure appears, dilatation of the main pulmonary arteries and of the right side of the heart takes place. At a late stage, the classical findings of right heart failure develop: venous distension in the neck, a tender and enlarged liver, peripheral edema, ascites, and hydrothorax.

How should these patients be treated?

The effectiveness of therapy is aided by early and accurate diagnosis. The principles of management can be divided into prophylactic, environmental, medical, inhalation therapy, mechanical, rehabilitative, and psychologic.

Prophylactic and environmental aspects include the avoidance of all inhaled irritants or pollutants, especially tobacco smoke. The prevention of respiratory infections, using influenza vaccine, dressing properly, avoiding excessive fatigue, eating properly with possible supplemental vitamins, and the early treatment of all pulmonary infections will prevent further damage to the lungs. Adequate humidification of the office and home environments to prevent too dry or too humid conditions, plus the filtration of offending allergens and other particles by air conditioning, enables the lungs to function more efficiently. The allergic patient should have a perennial desensitization program, and the avoidance of irritating factors tends to prevent acute bouts of bronchospasm.

Medical, inhalation and mechanical therapies include prophylactic and therapeutic use of bronchodilators, such as theophylline derivatives (Lanophylline, Elixophylline, Theokin, etc.), usually combined with expectorant drugs, and mucolytics (the iodides are still among the best). Corticosteroids (such as prednisone, 5 mgm.) may be used for short periods during acute attacks or for longer terms in selected, chronic patients. The use of humidification by large volume nebulizer, intermittent positive pressure breathing (IPPB) by compressed air compressors, with bronchodilators and/or mucolytic agents, improves ventilation of the lung and aids in the removal of secretions. For severe hypoxia, use continuous low-flow oxygen via nasal cannula, usually between one and three liters per minute to produce an arterial 0_2 of 50 to 60 mm. Hg. In patients with upper airway obstruction, tracheal fenestration should be considered to improve pulmonary ventilation. Basic proper breathing exercises may seem fundamental, but most of us are shallow breathers, and postural drainage will aid the elimination of bronchial secretions.

These respiratory cripples must have aggressive, continued, long-term treatment to maintain the results of therapy. Finally, they must be actively rehabilitated toward more normal living, physically, psychologically, and with vocational guidance.

What is the prognosis?

The long-term survival of these patients is related most closely to the severity of airway obstruction, as determined by measurement of forced expiratory volume in one second (FEV_1), maximum-expiratory flow rate or maximum voluntary ventilation. Patients with an FEV_1 greater than 1.25 liters, who have no other complicating disease, usually have a five-year survival rate, little different from normal persons of the same age, sex and smoking history. Patients with an FEV_1 less than 0.75 liters have a much less favorable prognosis, however, and if heart disease is present in these patients, a five-year survival is seen in approximately ten percent. As a group, patients with emphysema tend to have progression of their airway obstruction despite therapy, although some patients may actually have a stable or improving course for five years or more.

William G. Leaman, Jr., M.D. Fellow, Council on Clinical Cardiology, American Heart Association, edited this Brief for the Council of Education and Science in cooperation with the Pennsylvania Heart Association.

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CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.

obituaries

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Joseph W. Spelman,** Philadelphia; Yale University School of Medicine, 1944; age 52; died February 9, 1971. Dr. Spelman was president of the National Association of Medical Examiners, and at the time of his death was medical examiner for the city of Philadelphia. He was a Rockefeller Fellow in the department of legal medicine at Harvard University School of Medicine. He was a member of the American Association for the Advancement of Science, the American Association for Forensic Medicine, the College of American Pathologists, and the American Society of Clinical Pathologists. He is survived by his wife, two sons, a daughter and a sister.

○ **Clyde Malvern Stutzman, Jr.,** Muncy; University of Maryland, 1934; age 63; died January 30, 1971. He had recently retired. Survivors include his wife, three daughters, and a brother.

○ **Felix Peter Sugint,** Philadelphia; Jefferson Medical College, 1936; age 61; died November 22, 1970. He is survived by his wife.

○ **Maurice C. Wentz,** York; University of Maryland, 1916; age 80; died January 28, 1971. Prior to his retirement in 1969, he was head of the ear, nose, and throat department at the York Hospital. He was a member of the American College of Surgeons. Survivors include his wife, two daughters, and a brother.

○ **Ellis C. Winters,** St. Petersburg, Fla.; Medical Chirurgical College of Philadelphia, 1914; age 82; died February 8, 1971. He practiced in Ford City for forty years. He is survived by his wife, two sons, and a daughter.

○ **Maurice A. Aaronson**, Philadelphia; Medico Chirurgical College, 1916; age 78; died January, 1971. No information is available regarding survivors.

○ **John C. Barr**, Elizabethtown; University of Pennsylvania School of Medicine, 1951; age 49; died April 16, 1971. He was a member of the American Academy of General Practice. He is survived by his wife, his parents, one son, and one brother.

○ **Francis B. Boland**, Philadelphia; Jefferson Medical School, 1933; age 64; died April 12, 1971. He was on the staffs of St. Mary's and Nazareth Hospitals. He is survived by his wife, six sons, one of whom is Francis B. Boland, M.D., Philadelphia, and a brother.

○ **Francis J. Conlan**, Pittston; University of Pennsylvania, 1921; age 74; died April 5, 1971. He was a fellow of the American College of Surgeons and a retired chief of surgeons at Pittston Hospital. He was also a past president of the Luzerne County Medical Society. He is survived by his wife, a son, three daughters, and three sisters.

○ **William Edward Ford**, Emlenton; Temple University School of Medicine, 1933; age 65; died April 2, 1971. He is survived by his wife, a son, and two sisters.

○ **Morris Gallen**, Wyncote; Hahnemann Medical College and Hospital, 1931; age 74; died April 1, 1971. He was attending physician at the Home for the Jewish Aged. He is survived by his wife, a son, and two sisters.

○ **Clark G. Grazier**, Glenside; Jefferson Medical College, 1931; age 69; died March 25, 1971. He was a retired U.S. Navy captain. Survivors include his wife and two sons.

○ **Howard Elliott Milliken**, Harrisburg; University of Pennsylvania School of Medicine, 1920; age 74; died April 11, 1971. He was mayor of Harrisburg for eight years and was a past president of both the Dauphin County Medical Society and the Harrisburg Academy of Medicine. Former chief surgeon at the Polyclinic Hospital, he was a member of the International College of Surgeons, the American Society of Abdominal Surgeons, and the American Medical Association. He is survived by a son and a daughter.

○ **William N. Parkinson**, Haverford; Temple University School of Medicine, 1911; age 84; died April 19, 1971. He was dean of the School of Medicine at Temple University and medical director of the hospital from 1929-1959. He believed strongly in the concept of a medical center, and in 1961 the university formed its Health Sciences Center. Dr. Parkinson was vice-president in charge of the medical center from 1953 until his retirement. A fellow of the American College of Surgeons, he received the Strittmatter Award from the Philadelphia Medical Society and Father Shaffrey Award of St. Joseph's College. He is survived by two nieces and two nephews.

○ **Benjamin Franklin Souders**, Wyomissing Park; University of Pennsylvania School of Medicine, 1937; age 58; died March 24, 1971. He was head of the department of ophthalmology at the Reading Hospital and a former president of the Pennsylvania Academy of Ophthalmology and Otolaryngology. He was a fellow of the American College of Surgeons and a former president and secretary of the Reading, Eye, Ear, Nose and Throat Society. He is survived by his wife, a son, Thomas B. Souders, M.D., Wyomissing, two daughters, and a brother.

Robert Neil McAlpine, North Wales; Indiana University School of Medicine, 1955; age 46; died December 27, 1970. There are no known survivors.

Eugene L. Opie, Bryn Mawr; Johns Hopkins Medical School, 1897; age 97; died March 12, 1971. Dr. Opie was a pathologist, a medical author, and former head of the pathology department at the University of Pennsylvania. He was one of the original members of the Rockefeller Institute for Medical Research, where he worked until last fall. A son, three daughters, and a brother survive him.

Lorraine E. Ramsey, Pittsburgh; University of Pittsburgh School of Medicine, 1919; age 77; died March 10, 1971. He practiced general medicine for 50 years prior to his retirement in 1970. He is survived by his wife.

Lorenzo G. Runk, Jr. Philipsburg; University of Pennsylvania School of Medicine, 1934; age 62; died March 12, 1971. He was medical director for the Pennsylvania Department of Health, Region II, in Williamsport. No survivors are listed.

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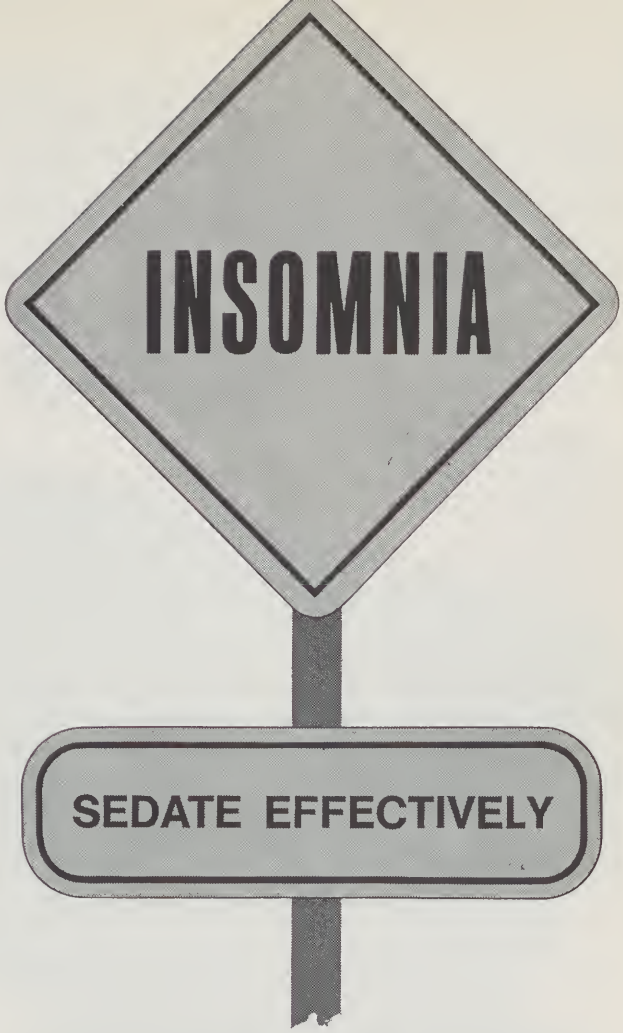

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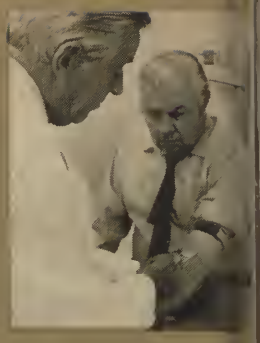

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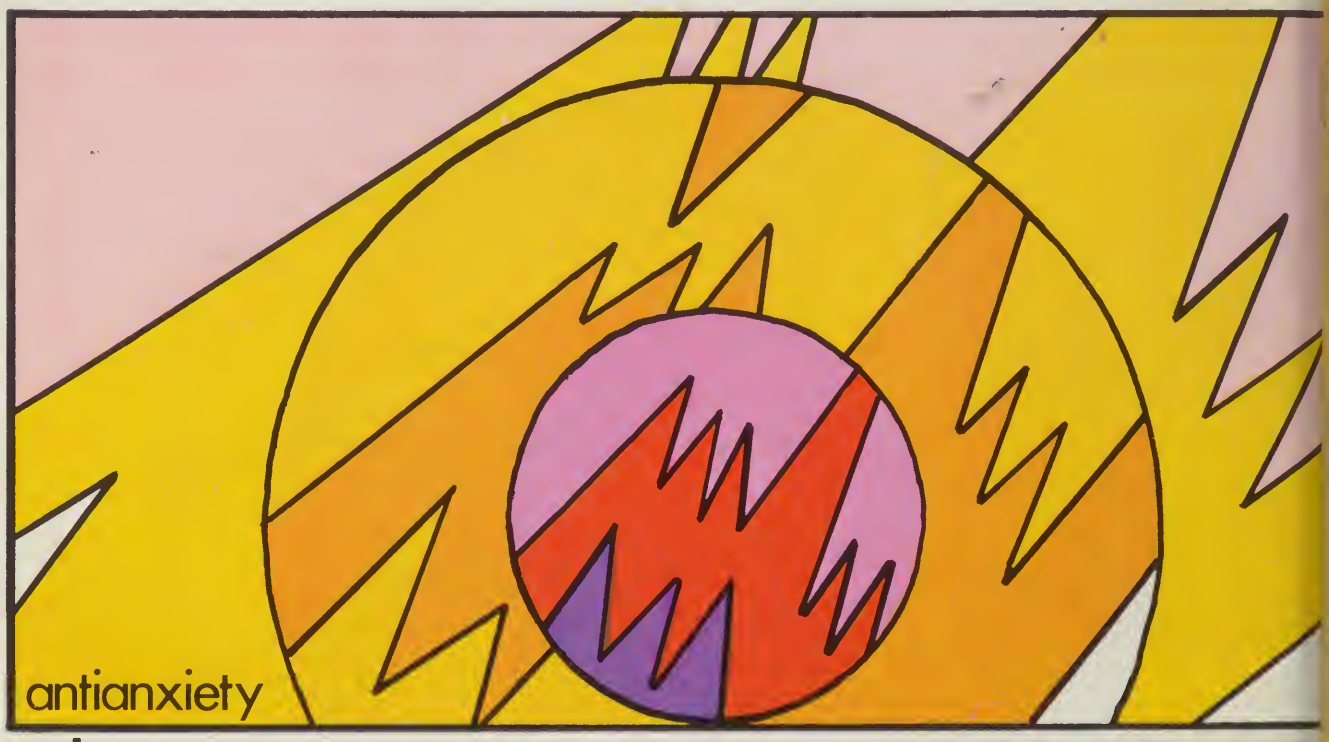

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies ma be present and protective measures ne essary. Variable effects on blood coagulc tion have been reported very rarely i patients receiving the drug and oral ant coagulants; causal relationship has n been established clinically.

Adverse Reactions: Drowsines ataxia and confusion may occur, esp cially in the elderly and debilitated. The are reversible in most instances by prop dosage adjustment, but are also occasio ally observed at the lower dosage range In a few instances, syncope has been r ported. Also encountered are isolated i stances of skin eruptions, edema, min menstrual irregularities, nausea and co stipation, extrapyramidal symptoms, i creased and decreased libido—all infr quent and generally controlled with dc age reduction; changes in EEG patter (low-voltage fast activity) may appe during and after treatment; blood dyscr sias (including agranulocytosis), jaundi and hepatic dysfunction have been r ported occasionally, making period blood counts and liver function tests a visable during protracted therapy.

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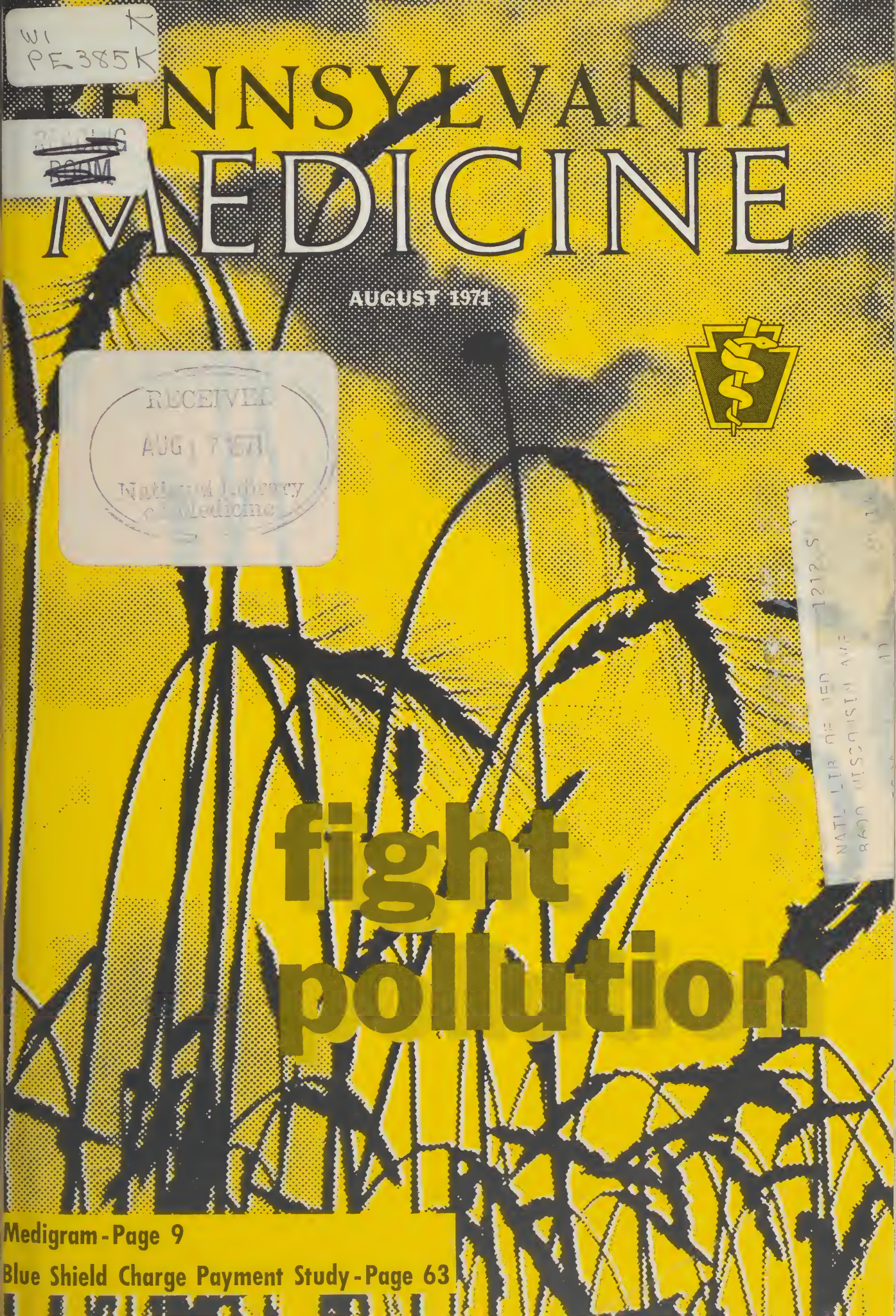

fight pollution

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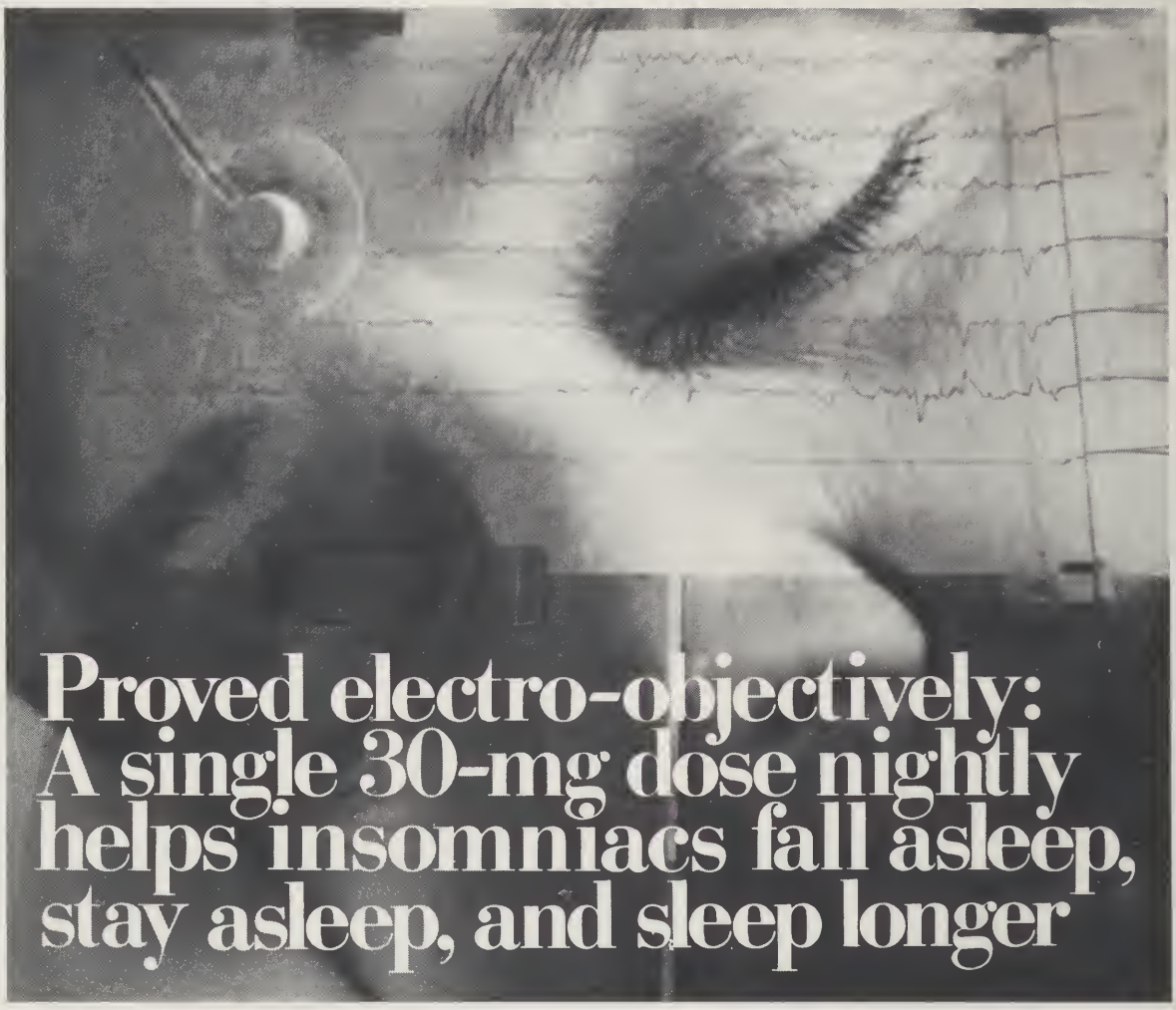


Proved electro-objectively: A single 30-mg dose nightly helps insomniacs fall asleep, stay asleep, and sleep longer

Controlled studies of 23 insomniac and 13 normal subjects treated with Dalmane (flurazepam HCl) in five sleep laboratories generated over 4000 hours of electroencephalographic, electro-oculographic and electromyographic tracings. These studies revealed that Dalmane 30 mg nightly usually induces sleep in 22 minutes and provides seven to eight hours of sleep.[1,2,3]

Moreover, Dalmane 30 mg was found to be useful in all common types of insomnia in which it was studied. Of drugs studied in a sleep laboratory,' Dalmane 30 mg was the only one that consistently reduced sleep induction time and maintained sleep nightly for 14 consecutive nights of use.

Confirmed clinically

Fifty-three controlled studies using a paired-night, double-blind crossover design have evaluated Dalmane clinically. In the majority of these, Dalmane (flurazepam HCl) significantly reduced sleep induction time and increased sleep duration. Dalmane and a placebo were alternated on successive nights in 2010 insomniacs, 1706 of whom were studied for a single night-pair, and the remainder for as many as fifteen paired-nights. A patient preference for Dalmane was apparent in the paired-night studies.

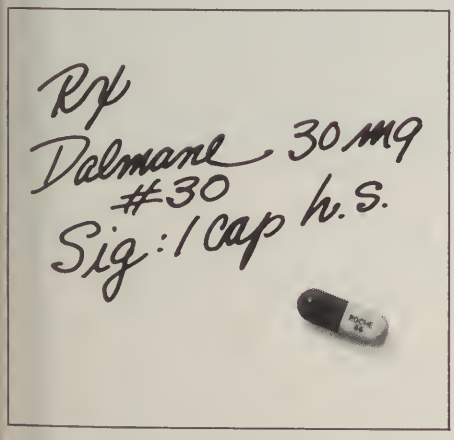
Dalmane was also preferred to certain hypnotics in two separate preference studies. In each of two double-blind studies, Dalmane 30 mg retained effectiveness for the total period of seven consecutive treatment nights, according to subjective/objective evaluations.

In summary, Dalmane is useful in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening. It can be used effectively in patients with recurring insomnia or poor sleeping habits, and in acute or chronic medical situations requiring restful sleep.

Dalmane (flurazepam HCl) is generally well tolerated

In most instances in which adverse effects with Dalmane were reported, they were mild, infrequent and seldom required discontinuation of the drug. Dizziness, drowsiness, lightheadedness and the like were the side effects most frequently noted, particularly in elderly or debilitated patients.[3] Instances of hepatic dysfunction, paradoxical reactions (excitement) and hypotension are rare with Dalmane, and morning hang-over is relatively infrequent. In studies to date the effectiveness of Dalmane for recommended periods of use is maintained without need to increase dosage.

References: 1. Kales, A., *et al.:* "Effectiveness of Sleep Medications: All-Night EEG Studies of Hypnotic Drugs," in Proc. 7th Internat. Cong. Electroencephal. and Clin. Neurophysiol., San Diego, Calif., Sept. 13-19, 1969. **2.** Kales, A., *et al.:* "Psychophysiological and Biochemical Changes Following Use and Withdrawal of Hypnotics," in Kales, A. (ed): *Sleep: Physiology and Pathology,* Phila., Lippincott, 1969, p. 331. **3.** Data on file, Medical Department, Hoffmann-La Roche Inc.



For the sleep your patients need

New **Dalmane®**
(flurazepam hydrochloride)

Before prescribing, please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.,* excitement, stimulation and hyperactivity, have also been reported in rare instances.

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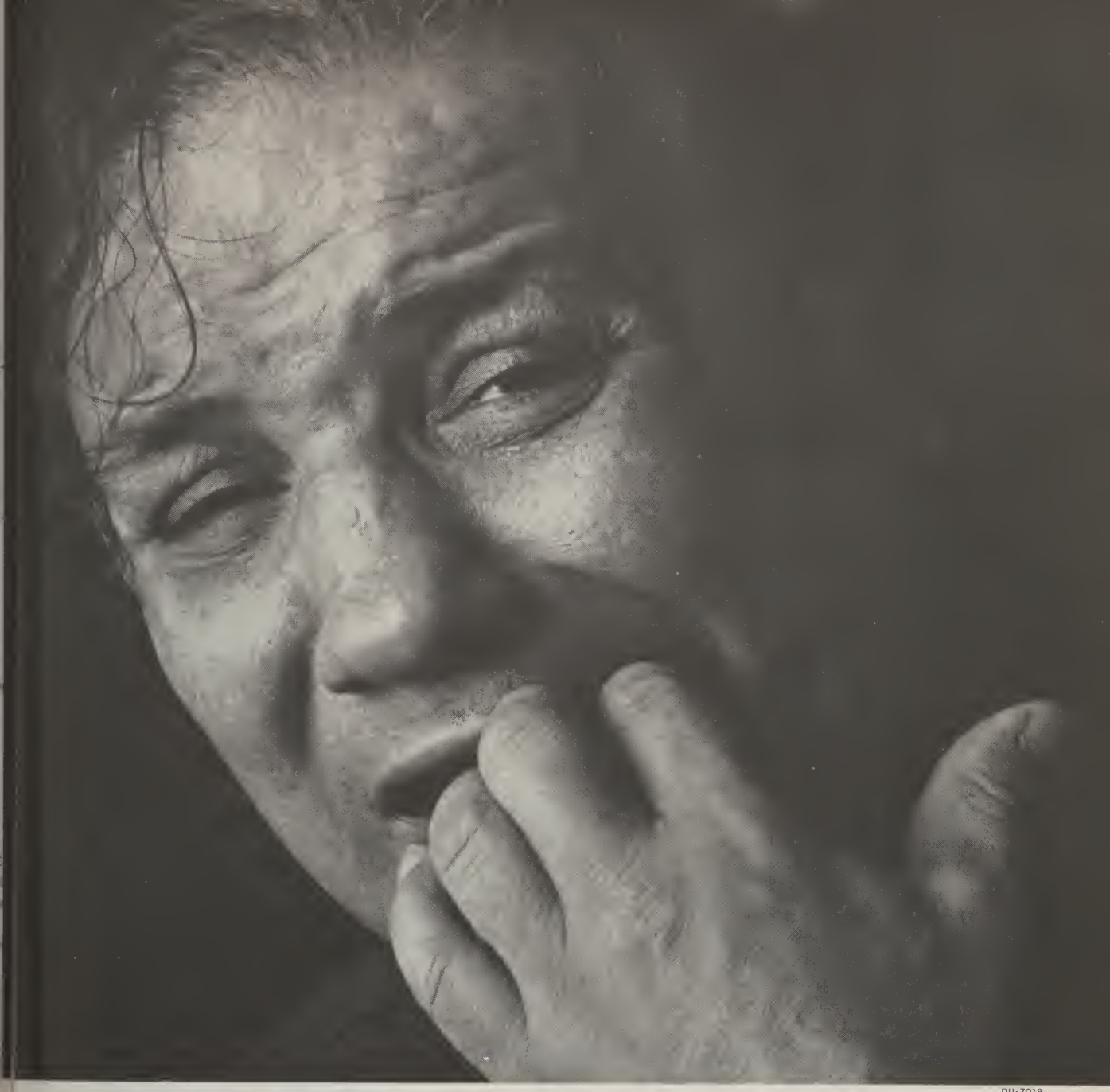

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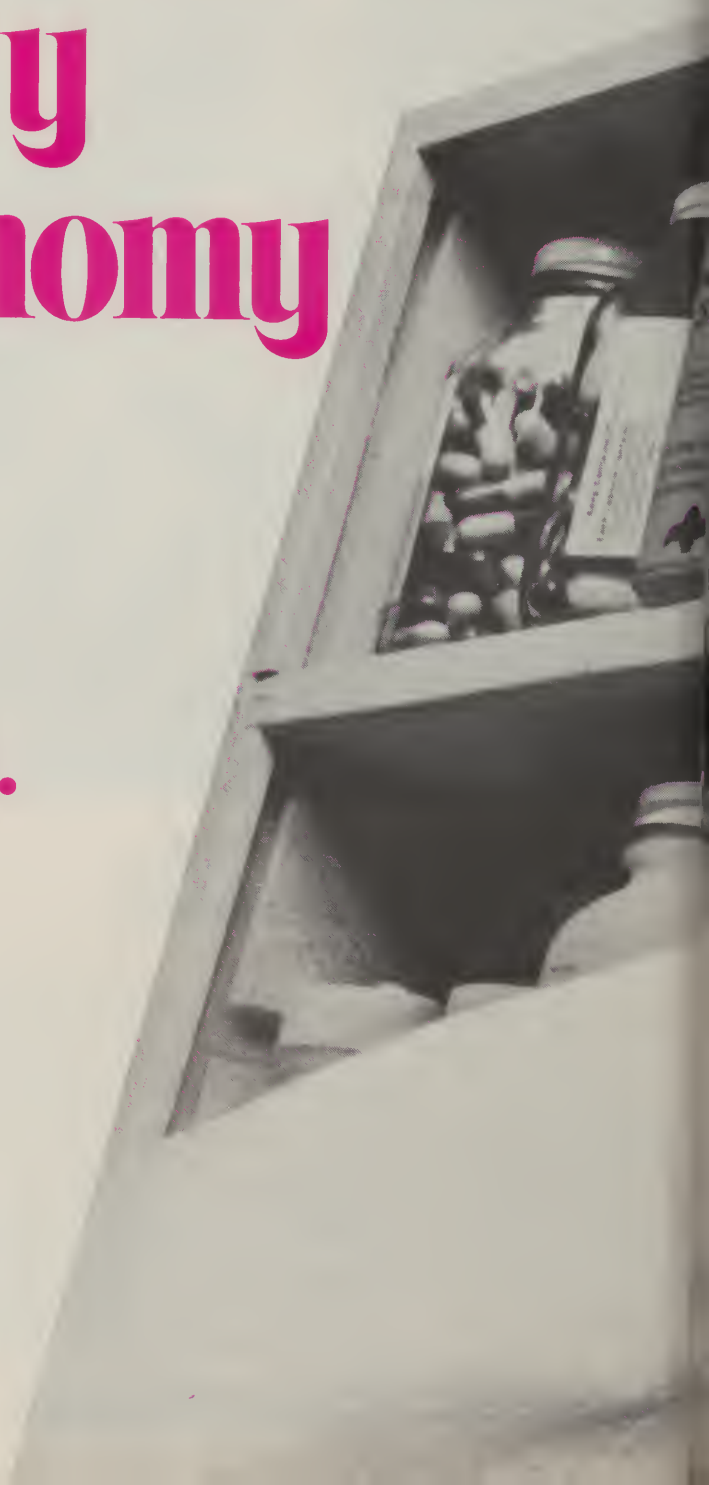

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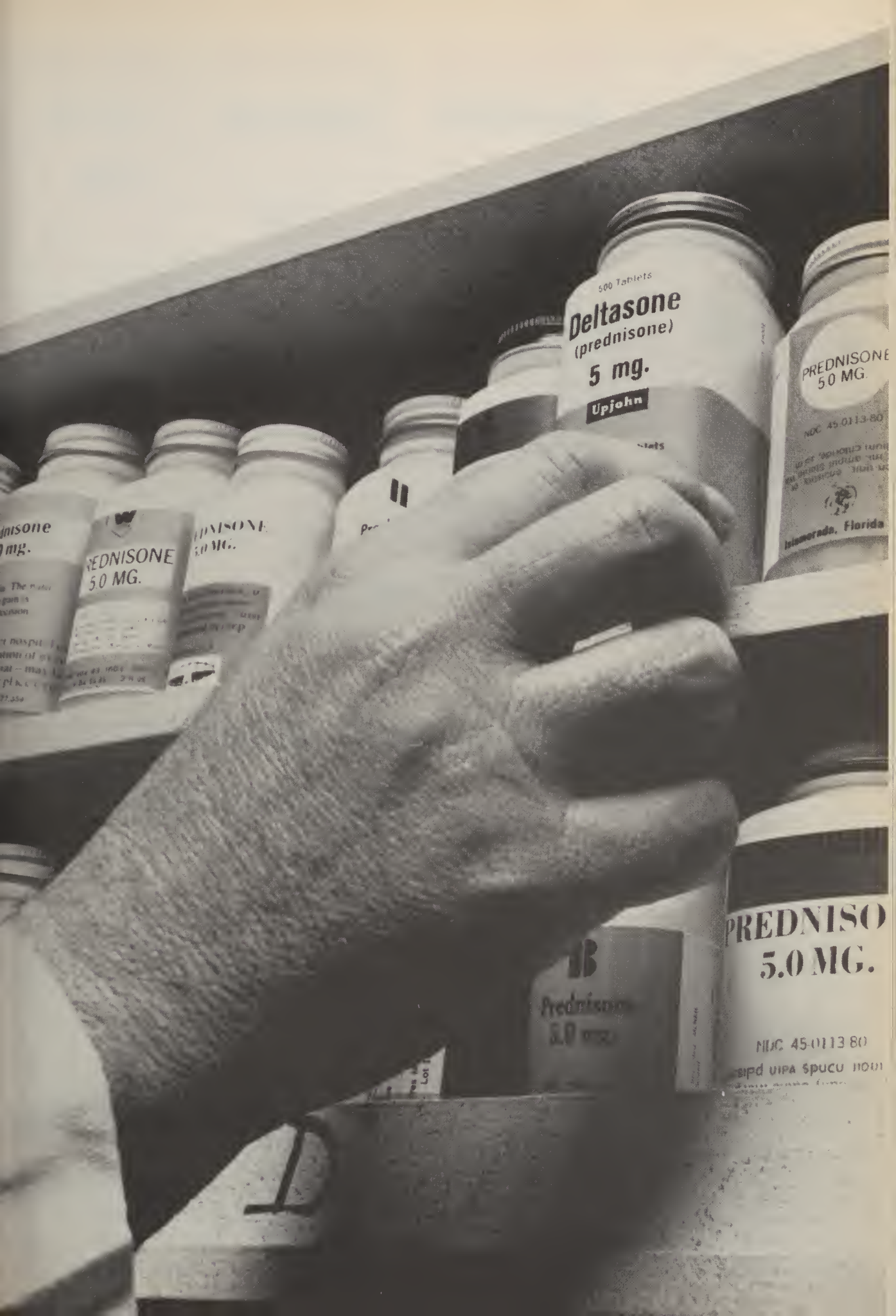
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Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptomatically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance doses of Deltasone (prednisone), however, keep this effect in mind and perform periodic serum potassium determinations in patients on prolonged corticoid therapy. Muscle weakness occurring with normal serum potassium levels may be due to disturbance in muscle metabolism. Severe myopathy is associated with substantial doses of steroids for prolonged periods, and evidence indicates it occurs more frequently with 9-alpha-fluro steroids. Replacement with non-fluorinated steroid has, in some instances, resulted in improvement.

Retardation of linear growth, roughly proportional to dose, has been noted in children on corticoids for six months or more. Following cessation of therapy, growth rate may be accelerated. Therefore, carefully observe growth of children on prolonged corticoid and if growth is retarded, reduce dose sufficiently to permit recovery before epiphyseal closure. Make every effort to avoid corticoids during pregnancy, since spontaneous remission of some diseases such as rheumatoid arthritis may occur. Long term corticoid therapy may evoke hyperacidity or peptic ulcer, therefore, as prophylaxis, an ulcer regimen and antacid are highly recommended. Take X-rays in peptic ulcer patients complaining of gastric distress, and, whether or not changes are noted, an ulcer regimen is recommended. Since prednisone causes less salt and water retention than many other glucocorticoids, patients should be observed closely for development of undesirable hormonal effects that are less obvious indications of steroid toxicity than edema and hypertension due to salt and water retention. Continued supervision of patients after cessation of therapy is essential, since there may be a sudden reappearance of severe disease manifestation.

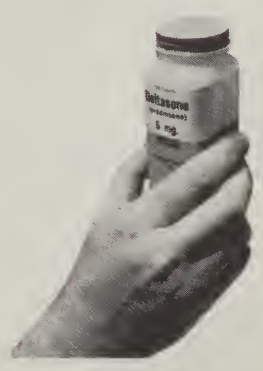
Adverse Reactions: Adverse reactions associated with use of corticoids include: Cushing's syndrome, moon facies, supraclavicular fat pads, hirsutism, striae and acne; relative adrenocortical insufficiency particularly in time of stress due to trauma, surgery or severe illness; protein catabolism with negative nitrogen balance; electrolyte imbalance; alteration of glucose metabolism with aggravation of diabetes mellitus including hyperglycemia and glycosuria; osteoporosis reversible only with difficulty; spontaneous fractures; aseptic necrosis of the hip and humerus; activation and complication of peptic ulcer including perforation and hemorrhage; aggravation or masking of infection; increased blood pressure; convulsions; petechiae and purpura; menstrual irregularities including amenorrhea, spotting or prolonged bleeding; insomnia; psychic disturbances especially abnormal euphoria; nervousness; posterior subcapsular cataracts occasionally requiring extraction; increased intraocular tension; increased intracranial pressure with papilledema (pseudotumor cerebri); pancreatitis; necrotizing angiitis; thinning of scalp hair; suppression of growth in children; thromboembolic complications; facial erythema; allergic skin reactions; ulcerative esophagitis; sweating; vertigo; weakness; myopathy; headache; exophthalmos. Adverse reactions are usually reversible and usually disappear when drug is discontinued.

Supplied: 2.5 mg., scored—bottles of 100 tablets. 5 mg., scored bottles of 100 and 500 tablets and cartons of 100 tablets in 10 strips.

For additional product information, consult the package insert or see your Upjohn representative.

MED B-1S (KC

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001



Deltasone® 5 mg. (prednisone, Upjohn

an economical prednisone that's made a name for itself

Sprigg codes Subber hayfeber Awtubb allerdgies Widder "flu"

relieve them all with all-season ISOCLOR®

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TWO ACTIVE COMPONENTS
give "four season" sufferers dependable relief

Chlorpheniramine Maleate dries runny noses and eyes, quiets sneezing, wheezing, soothes itching and reduces postnasal drip—all with a particularly low index of side effects such as drowsiness.

Pseudoephedrine HCl: decongests throughout *entire* respiratory tract, opening nasal passages, dilating bronchioles, relaxing "tight chest"—as effectively as ephedrine, but with much less CNS or cardiovascular stimulation.

COMPOSITION: Each tablet or 10 cc. (2 teaspoonsful) of liquid contains:

Chlorpheniramine Maleate ..... 4 mg.
Pseudoephedrine HCl ..... 25 mg.

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Chlorpheniramine Maleate ..... 10 mg.
Pseudoephedrine HCl ..... 65 mg.
In a special pellet form providing both prompt and sustained effect.

INDICATIONS: For relief of upper respiratory and bronchial congestion associated with: the common cold, hay fever and allergies, sinusitis, influenza, and vasomotor and allergic rhinitis.

CONTRAINDICATIONS: Sensitivity to antihistamines or sympathomimetic agents. Severe hypertension or severe cardiac disease.

PRECAUTIONS: Use with caution in patients with hyperthyroidism. Patients susceptible to the soporific effects of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

CAUTION: Federal law prohibits dispensing without prescription.

SUPPLIED: Tablets: Bottles of 100; Liquid: Pints and gallons; Timesules: Bottles of 50, 250, and 1000.

DOSAGE AND ADMINISTRATION:	Tablets	Liquid	Timesule
Adults:	1 q. 3-4 h.	2 tsp. q. 3-4 h.	1 q. 12 h.
Children 6-12 years:		1 tsp. q. 3-4 h.	
40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

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At last-an answer to your malpractice protection anxiety.

An insurance program sponsored and supported by the PMS.

The Pennsylvania Medical Society has been increasingly concerned about the problems faced by its members in securing and retaining professional liability insurance. There has been a growing tendency for insurance carriers to arbitrarily cancel, or not renew, professional liability insurance contracts for reasons entirely beyond the physician's control.

The obvious answer had to be a program, sponsored by the Pennsylvania Medical Society, designed to provide its members with *long term* coverage, adequate limits, at the best possible cost, in addition to giving the Society an opportunity to participate in the policy-making and administration of the program.

Such a program, more progressive and comprehensive than any that has been made available to any medical group, now exists. It is being underwritten by the Argonaut Insurance Company, a well established, "A+AAAA" rated casualty insurance carrier with assets in excess of $180,000,000 and considerable experience in the medical liability field. The exclusive, full-time administrator of the program is Parker & Co. Inc. of Pennsylvania, one of the country's leading insurance brokerage firms.

In review, the major points of the program are:

1. The Pennsylvania Medical Society has entered into an agreement with the Argonaut Insurance Company to administer the program through Parker & Co., Inc. of Pennsylvania.
2. The Argonaut Insurance Company will be bound to make this program available for a *minimum of five years. No* other carrier has offere such an agreement.
3. The Society participates through Professional Liability Insuranc Commission consisting of twelv members. The Commission will b the ultimate authority in appea stemming from disputes betwee member insureds and will work i close conjunction with the local di trict committees.
4. No member's application will be d clined except by the *joint decisio* of the PMS Commission and th Argonaut Insurance Company.
5. Full liability coverage of $100,0(for each claim with an annual aggr gate limit of $300,000 with exce limits up to $1,000,000 availabl Coverage *is* available for interns, re idents and physicians' and surgeor assistants.
6. Rates are competitive with oth major writers of professional liab ity insurance in Pennsylvania.
7. There is no requirement that member purchase ancillary insu ance coverages (homeowners, aut etc.) in order to participate.

This program offers PMS memb a unique opportunity to stabilize th professional liability insurance cov age on a long term basis. However broad based, high degree of memb ship involvement is essential to ma this program a success. Please fill c the coupon indicating your interest participating in the PMS endorsed p gram when your present cover expires.

Argonaut Insurance Companies

Mail to:
Parker & Co., Inc. of Pennsylvania
1616 Walnut Street, Philadelphia, Pennsylvania 19103
Attention: Mr. A. John Smither, Vice President

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Office Address _____

Telephone No. _____

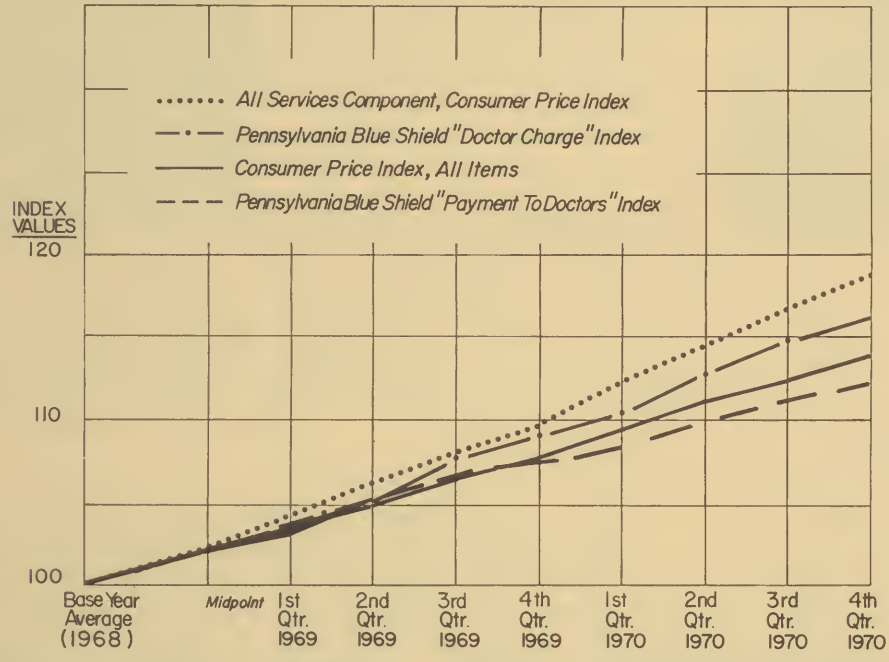
Medical Specialty _____

Date your professional liability insurance expires _____

Present Carrier _____

I am interested in participating in the PMS Professional Liability Insurance Program. Please send me an application. ☐

LUE SHIELD CHARGE-PAYMENT INDEX SYSTEM REVEALING Despite public and political ries that physicians' fees have risen out of proportion to any oth- r price rises during the period of inflation the nation is suffer- ng, statisticians at Pennsylvania Blue Shield, using actual figures s well as the Consumer Price Index, have come up with the interest- ng fact, illustrated on the chart below, that by the end of 1970, hysicians' fees rose 16.2 percent over the base average year of 1968. Blue Shield payments increased 12 percent, while the All Services omponent of the Consumer Price Index rose 18.7 percent. Be sure to ead the story on page 63 of this issue of PENNSYLVANIA MEDICINE.



DR. LIMBERGER SPEAKS ON HMO'S PMS President William A. Limberger, M.D., spoke at the recent dedication of the Mon Valley Community Health Center in Monessen, and explained HMO's and the PMS foundation concept. The health center was built through the voluntary efforts of a number of community organizations with the goal of providing comprehensive health services to the people in the non-urban valley of the Monongahela River in southwestern Pennsylvania. The text of Dr. Limberger's speech will be carried in the September issue of PENNSYLVANIA MEDICINE.

PUBLIC EDUCATION ON VD PLANNED The Pennsylvania Pharmaceutical Association is conducting a public education campaign to halt the dangerously growing incidence of venereal disease. Member pharmacists in the state will display during the month of August educational materials on the use of available devices to prevent the spread of VD. Secretary of Health J. Finton Speller, M.D., has described the situation as one of the major health problems in the Commonwealth, and throughout the world. "What is needed," Dr. Speller said in a recent interview, "is a reliable blood test to determine the presence of gonorrhea. Many people harboring the disease are asymptomatic." He said, "Such a test could be forthcoming through more research at the federal level."

PENNSYLVANIA HEALTH CONFERENCE SCHEDULED The 1971 Fall Health Conference will be held this year September 12-14 at the Penn Harris Motor Inn, Camp Hill. An electronics game called Stapol will permit those attending an opportunity to look into the future--specifically "The Health Scene-1985." For further information write: Pennsylvania Health Conference Committee, 2 Clemson Dr., Camp Hill, Pa. 17011.

SOCIETY SEEKS ANSWERS FROM WELFARE DEPARTMENT PMS President William A. Limberger, M.D., in a letter to Secretary of Welfare Helene Wohlgemuth, again requested a meeting with Welfare Department representatives to discuss the Commonwealth Medical Assistance Program, and particularly the utilization review requirements and related statements contained in Medical Assistance Memorandum No. 16, issued June 3 to physicians and dentists. Dr. Limberger's letter specifically requested clarification of the following aspects of the memorandum: 1. Cumbersome requirements for processing claims for medicare-medicaid recipients; 2. Level of reimbursement for physicians, particularly those who treat a large percentage of M.A. recipients; 3. Cumbersome and restrictive requirements for reimbursement for radiologists who elect to bill separately for services rendered M.A. recipients; 4. Unnecessary requirements for refilling drug prescriptions; 5. Undesirable and unnecessary wording on Invoice Transmittal Form PA-259; 6. Inadequate claims processing system which does not facilitate prompt payment and does not itemize services for which payments are being made; 7. Grossly inadequate outpatient benefits.

ANNUAL DINNER SCHEDULED The twenty-fourth Annual Dinner of the Pennsylvania Medical Society will be held at the Pittsburgh-Hilton Hotel on October 5, 1971. Further information and coupon to reserve tickets appear on page 78 of this issue. The reception before dinner is being given with the compliments of Parker and Co., Inc., of Pennsylvania and Argonaut Insurance Co., the companies which co-sponsor, with the Society, the PMS Group Malpractice Insurance Program.

DIALYSIS PROGRAM MOVING At least eleven institutions have been approved by the State Renal Dialysis Advisor Committee to treat Pennsylvania citizens suffering from kidney disease. Applications from institutions are being reviewed on a continuing basis. The Department of Health is now processing patient applications from approved institutions where, according to Secretary of Health Speller, patient treatment is scheduled to begin as soon as applications are approved. The first institutions approved are: Geisinger Medical Center, Danville; Hahnemann Medical College, Albert Einstein Medical Center, Lankenau Hospital, and Thomas Jefferson University Hospital, all in Philadelphia; Allentown Hospital Association; Bryn Mawr Hospital; Crozer-Chester Medical Center, Chester; Pittsburgh Veterans Administration Hospital and Presbyterian-University Hospital both in Pittsburgh; and Hamot Hospital, Erie.

Secretary of Health a 'doer' and idea man

DR. SPELLER

David J. Smith, M.D., medical editor of PENNSYLVANIA MEDICINE, interviewed J. Finton Speller, M.D., Philadelphia urologist who gave up his plan for retirement to assume the head of the Pennsylvania Department of Health. Farmer, art student and collector, lay pastor of his church, aviator and yachting enthusiast, the secretary has moved quickly to revitalize the department. Some of his plans are expressed in this interview.

DR. SMITH

. Dr. Speller, in your opinion, what is e single most important health oblem we have in Pennsylvania?

. It's difficult to say but if I had to pick ıe problem, the delivery of health .re, especially in the rural areas, is obably the most important. Some ays must be found to increase the nount of care and to assure that the ıality of care will remain high so that eople in the rural areas have near the me access to medical care that people suburban and city areas have.

. What other health problems do you el need immediate attention?

. You know, when we used to talk out health problems many years ago, ıe subject was pneumonia or influen-ı. When I began studying medicine the iggest thing in the medical book was phoid fever. We never thought when ou and I were going to school that rug abuse would be the problem it is day and it is a health problem. Of ourse, it's a social problem primarily, ut it is one about which the Depart-ıent of Health is very concerned. It is ne of the reasons that we say health an no longer be separated from social ervices. We are very interested in the rug abuse rate. In Philadelphia alone, 0,000 juveniles are addicted to heroin, nd most have a $100-a-day habit. aking two million dollars a day out of he economy makes it quite a problem. 've been harassed by colleagues and statisticians who tell me that 20,000 is a low figure. They say 30,000 is more accurate. We predict in 1971 it will be the highest cause of death in the age group between 15 and 25, killing well over 55,000 people in the United States. Some 40,000 in the same age group are killed annually by automobiles and even fewer in the Asian conflict.

Q. The Pennsylvania Medical Society has just published a report on emergency medical services. Do you think state government in the near future will make efforts to improve emergency medical care in Pennsylvania?

A. Yes. I don't know what steps will be taken first. We have talked to Dr. John Howard who is president of the Pennsylvania emergency physicians group. Their statistics show that many people die who could have lived if emergency medical services had been up to the standards they recommend. These are statistics that can't be denied. I was surprised at the numbers of people in Pennsylvania alone who were dead on arrival at the hospital because certain emergency procedures and transportation to the hospital were not available. There is a lot of pressure on the General Assembly to keep the state out of delivering health care, and this includes emergency medical care. However, our constitution says the government must do for the people what they can't do for themselves. This is why we are in renal dialysis at the present time, to help doctors help patients.

Q. Do you feel that there are standards a doctor should meet before his license can be renewed?

A. When I say emphatically no, you'll think it's because I'm a doctor but that's not the case. I know doctors who feel they must go to every medical convention but I wonder how much they absorb. I oppose this also because the supply of doctors is considered short. There is some question about whether it is a matter of supply or distribution. But, let's assume that we need more physicians. When you add more requirements on what is already a rigorous medical education you will cut down the incentive of a lot of people to study medicine.

Q. Dr. Speller, what do you feel is the value of any enforced continuing medical education?

A. I have an idea we are trying to get adopted by the General Assembly but every time I get ready to introduce it the bottom drops out of the fiscal policy. I'm really not as opposed to continuing education as I appeared to be when I made my first statement but I wanted to block out of your minds all the old ideas and give you my thought. I do not believe that you can get much out of spending an hour reading a medical journal. Nothing is wrong with sem-

inars, but I don't think they generate the amount of experience that is necessary to really train a man. I think the best way to train a man is to give him a residency. In a residency you learn by doing. We need residents in the hospital; we need hands in the hospital. A man could go away or stay in his home city. He enrolls as a resident in a hospital for three months every three or four years. During the three months he could rotate through as many services as he needed. The state would have to underwrite the cost. A man can't give up his practice. He must have an income to maintain him for those three months. If he is in a practice he must have somebody to take over his practice during this time. Two features in this program are very attractive. Hospitals will have more hands at a salary they can afford and the man will get training in the institution of his choice and it will be dynamic, active training. This can be done through the AMA or the State Society. Those who have specialized can be eliminated. For the generalist, it should be a must. But you can't use enforcement without giving advantages.

Q. Doctor, will you reiterate your position that all health services be transferred from various departments, primarily from the Department of Welfare, to the Department of Health?

A. We are interested at the present time in the control by our department of the ten state general hospitals— control of their operation, and in the control of inspections of hospitals and nursing homes. I do not think that all health operations have to be moved immediately into the Health Department. Some of them can be operated in other departments, but if they are operated elsewhere, the Health Department should have some degree of control over them. For instance, the Board of Medical Education and Licensure is in the Department of State but the Department of Health exerts more influence on that board than the State Department does. In effect we control that board and it isn't difficult at all. One of the reasons they were moved out of the Department of Health is that the general public and consumers as well as the General Assembly didn't feel that the people who provided the health care should completely control it at the same time. There is some rationale to this thinking. A degree of control over them by the Department of Health is necessary. The drug abuse programs that are in the Welfare Department should have Health Department input and have some degree of control. One of the reasons these programs were taken out of the Health Department was that there was a fear that the Health Department would become an entrenched bureaucracy with a tremendous amount of power. A project in one department can be controlled in part by another department. In this way too much control by one department can be avoided.

Q. What about inter-agency cooperation? Is it increasing?

A. I think this is growing. And it's growing by mutual consent. Between health and welfare and between labor and industry, cooperation is increasing. We are meeting together successfully. After the Temple Health Maintenance Organization (HMO) was started, twenty-seven other applications from around the state have been received by the Welfare Department. The Health Department suggested the state go slow on this. First, why go out into twenty-seven when we don't even know how the first one will go? The first one will give the state a little experience. It is true that Governor Shapp mentioned six pilot HMO's, but he didn't put a timetable on them.

Q. In regard to HMO's the one at Temple is patterned after Kaiser-Permanente. The Philadelphia group is a high-risk group of people who come in only in crisis situations. Won't this increase expenses?

A. An HMO presumes that it'll be prepaid; that it will be disease preventive and illness preventive where possible. If you have a crisis-oriented clientele, and this is found in the innercity groups, you might not be able to carry out the principles of the HMO as easily as you can carry them out in the Kaiser-Permanente group, or among people who are motivated to come in because they don't want to get sick. Some of the innercity dwellers, especially the ones on medical assistance, don't have as much stake in their own lives as the fellow who has a good job. What this means is that they become crisis oriented. I've worked in a comprehensive health planning group and found it didn't work well. The program didn't make any significant contribution except to offer availability of crisis treatment to innercity dwellers.

Q. What programs are being promoted by the Health Department to deliver increased health care in the state's rural areas?

A. Well, as you know, we have two problem areas in health care delivery—the innercity and the rural areas. The innercity is not as devoid of health care facilities as the rural areas. In the innercity people are near large hospitals and clinics, if they wish to use them, but the family in a rural area where there isn't a doctor within fifty miles is in a trouble area. We have been considering in the last few weeks the best ways to deliver care to the rural areas. Comprehensive health clinics and comprehensive groups of physicians must be encouraged with state backing and federal backing to locate in areas that we consider medically deprived. But such a plan would require approval by: 1. The consumers; 2. The country medical society which represents the doctors in the area; 3. The Pennsylvania Medical Society, which keeps very accurate records of the medically deprived areas of the state; and 4. The Department of Health. All four must agree that this is a medically deprived area and then we would bend every effort to try to get established some form of health facility in this area.

Grant permits research to proceed

The John A. Hartford Foundation of New York City has awarded a grant of $95,300 for a year's continued research in preserving organs for future transplants. Under the direction of Herndon B. Lehr, M.D., chief of plastic surgery at the University of Pennsylvania Hospital, additional studies are being made on freezing and thawing tissues and organs for the purpose of establishing a supply bank of organs for surgical replacement of diseased or nonfunctioning parts of the human body.

A study supported by a previous Hartford grant was reported in a paper entitled "A Viable Organ Bank," published in PENNSYLVANIA MEDICINE in October of 1970.

Physicians Assistants now formally organized

The Physicians Assistant, (PA) newest professional on America's health team, has formally organized with the opening of a national office of the American Association of Physicians Assistants in Tampa, Florida.

The AAPA under the guidance of Sanford Pinna, M.D., director, and Frank Norton, M.D., executive secretary, has embarked on a program to define precisely the roles of the P.A. in health care delivery systems and to expedite proper, effective assumption and maintenance of these roles.

"Health care delivery now lags far behind capability in many areas of the country," said Dr. Pinna. "The Physicians Assistant," he continued, "will be a key factor in bringing about grass roots delivery of optimum health care."

Main elements in the AAPA program will be: liason with educational and government institutions and with employers; and in-service, function-tailored education for members to provide continuous upgrading of their professional status.

The AAPA will coordinate its activities closely with the AMA and other physicians' organizations in order to promote achievement of a common goals.

The AAPA has established an information center for members in which they are put in touch with universities and hospitals now offering formal training programs leading to certification. At present, there are approximately twenty schools and hospitals throughout the country offering such programs. A Physicians Assistants Placement Bureau is being formed to provide interested physicians and hospitals and prospective assistants with a medium through which they may contact each other.

Further information is available from the American Association of Physicians Assistants, 1111 North West Shore Boulevard, Tampa, Fla.

Pennsylvania chosen for nursing profession study

Pennsylvania is one of nine states designated by the National Commission for the Study of Nursing and Nursing Education as model areas for the testing of the commission's recommendations for the nursing profession.

Leroy E. Burney, M.D., retired U.S. Surgeon General and president of the Milbank Memorial Fund, is president of this national commission. He stated that information acquired from this pilot program will be used in the establishment of joint state practice commissions and a statewide master planning committee for nursing education to improve the level of competence in the field of nursing.

The national commission will serve as advisors and consultants to the several state committees.

New rehabilitation center to open

Gateway Farm, a new alcoholic rehabilitation center designed to serve a tri-state area will open in Western Pennsylvania on January 1, 1972, under the medical directorship of Abraham J. Twerski, M.D., director of the department of psychiatry at St. Francis General Hospital, Pittsburgh.

An outgrowth of the St. Francis alcoholic clinic, it will be located in Beaver County, serving an area with a ninety-mile radius, in which there are an estimated 220,000 alcoholics.

It will be a 150-bed post-detoxification center based on the concept that the alcoholic cannot be treated, educated to his problem, and then released into the same sociological situation from which his illness stemmed. After the initial rescue, detoxication, education, and rehabilitation, he must receive long-term support so that he has the security to become a positive force in his life situation, rather than a victim of it, according to Dr. Twerski.

Secondarily, the facility will concentrate on training personnel in the handling of alcoholism and its related field, sedativism.

Treatment will begin where emergency alcoholism hospital clinics end. The average estimated length of stay will be about four weeks. The staff will work with a ratio of one therapist to each ten patients. It will consist of social workers, psychologists, medical, religious, and nursing personnel. Vocational and recreational therapy is an important adjunct of the program. About 50 percent of the staff will be recovered alcoholics.

An extensive program of group therapy, lectures, films, discussions, and individual sessions are to be conducted. Psychological testing, psychiatric consultation, work therapy, and family therapy where indicated, will form part of the routine treatment.

Warning issued on hexachlorophene use

The American Academy of Pediatrics' committee on environmental hazards has warned physicians and parents that some products intended for oral use (certain toothpastes and throat lozenges) contain hexachlorophene that has caused the death of a toddler who ingested a few ounces of a three percent solution. The academy statement made recently said, "Deaths also have aparently been caused when the chemical was absorbed after application to badly burned skin of children and adults." An additional warning said: "Repeated washes of or applications of wet dressings to badly injured skin with hexachlorophene solutions, as in the treatment of burns or generalized eczema, are also potentially dangerous and are not recommended by the Committee."

Dr. Clammer Retires

The Greater Delaware Valley Regional Medical Program (GDVRMP) has announced the retirement July 1 of George R. Clammer, M.D., executive director.

Martin Wollman, M.D., former deputy director, and now acting executive director, succeeds him.

William F. Kellow, M.D., vice-president and dean of Jefferson Medical College, recently reelected chairman of the GDVRMP Board of Directors, commended Dr. Clammer for his leadership in bringing people with many interests within the medical profession together in implementing the program.

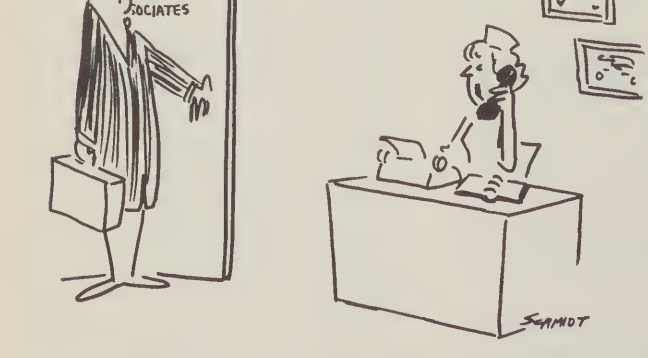
Should all automobile accident victims be autopsied?

To The Editor:

The recommendation by the 1970 Commission on Emergency Medical Services of the Pennsylvania Medical Society, as reported in PENNSYLVANIA MEDICINE of June 1971, that all victims dying as a result of automobile accidents in Pennsylvania should be autopsied has the virtue of recognizing that in the past in many jurisdictions in the state outside our larger cities autopsy examinations were performed in insufficient numbers on the victims of fatal traffic accidents. There is, however, some question whether a law to that effect is really necessary. Nobody will deny the fact that much can be learned from thorough autopsy examinations of traffic accident victims if the data are correlated with an on-the-scene investigation by traffic experts as well as an examination of the death vehicle. The commission may be aware of the fact that such a study was performed a number of years ago by Gikas and associates.[1] This exemplary study encompassing the experience in a medical examiner's system in Michigan brought out some significant facts concerning the investigation of traffic fatalities, among which were the importance of certain design features in earlier model cars which were shown by the authors to be directly responsible for lethal injuries in the "second collision" between the occupant and his car, and also provided impressive evidence that the data collected at autopsy (apart from the establishment of an anatomical cause of death) only acquire true significance if placed in the context of a professional traffic accident investigation. If the autopsy record is considered alone it represents no more than a catalogue of single or multiple fatal and non-fatal injuries in varying combinations, the value of which in terms of accident prevention is probably limited. One result of the Gekas study was that the auto makers in Detroit were persuaded to eliminate many of the hostile projections in the car interior typical of earlier models and another was more convincing evidence of the role of poor road design or inadequate road markings in traffic fatalities where comprehensive investigation was carried out leading to appropriate correction of traffic hazards.

There is presently a shortage, not only in Pennsylvania but nationwide, of pathologists who have time to do such autopsies in the way they should be done for the purpose of meaningful documentation. It has to be realized that an autopsy on an accident victim with multiple injuries can be very time consuming and complex. The diagnosis of fractures is certainly more easily established by X-ray than by autopsy examination and further contributes to the high cost of such investigations. In most counties operating under the coroner's system the funds available for the investigation of deaths by the coroner are limited and the use of these funds for the investigation of traffic deaths would result in a reduction of available funds for the investigation of other types of death of equal importance, from a legal and social point of view. The serious budgetary difficulties in which the Commonwealth finds itself would make it less than likely that more funds will be made available by the state to investigate this type of fatality more thoroughly unless the need for it can be clearly demonstrated. In a substantial number of auto accident fatalities the cause of death is perfectly obvious and the cause of death may be established without a formal autopsy being performed. The drawing of a specimen of the victim's blood for an alcohol determination may be all that is necessary. In other cases where no externally visible lethal injuries are present and the cause of death is not obvious on inspection, or where there is a question whether a sudden natural illness was actually the cause of the accident, a complete autopsy should be performed. The danger of a law requiring that *all* traffic fatalities be examined by autopsy is that professional time and financial resources will be diverted from the investigation of other types of death, not certifiable without an autopsy. Unquestionably we need a more scientific approach to the investigation of serious or fatal traffic accidents, but there is reason to believe that the desired information can also be obtained by limited pilot studies, such as those by Gekas in Michigan, which would give a reading of the character and the extent of the epidemiological problem of traffic fatalities. It is not likely that such data in Pennsylvania would be substantially different from those that were obtained in Michigan.

Anthony E. Maas, M.D.
Associate Pathologist
Harrisburg Polyclinic Hospital



Good Morning— DAM doctors office.

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Cable TV provides continuing education for doctors

The physicians in three Pennsylvania counties, Berks, Lycoming and Lehigh, have a unique opportunity for continuing medical education, utilizing closed-circuit cable television, which has been tested for almost a year in only eight counties throughout the nation. This is how it works.

In Berks County, television programs are beamed toward physicians by the Berks County Medical Society in cooperation with the Community Medical Cable Casting Co. (CMC) of New York City, Roche Laboratories, and a local CATV cable company (Berks TV Cable Corporation).

Video tapes designed to keep physicians abreast of developments in various fields of medicine, funded by Roche, and produced by CMC, are telecast and delivered by a special arrangement designed to be viewed in physicians' homes or offices equipped with demodulating devices. The physician turns his set to Channel 12, then utilizes his demodulator, which cuts out the program in progress and brings in the medical broadcast.

These devices are furnished free by CMC to physicians, the only requirement being that they be regular cable subscribers. The programs are carried four evenings a week. Every two weeks a new series of tapes is shown. The series usually consists of three segments continuously broadcast for a full hour's education.

Begun in September of 1970, subjects already covered have included relief of pain, radioisotope arteriography, rubella immunization, late developments in kidney transplants, diagnosis of educationally/neurologically handicapped children, and chromosome abnormalities. Programs are predominantly clinical in nature, but research and paramedical programs are often included.

Sherwood C. Young, executive director of the Berks County Society, has been a leader in the national program for developing continued education programs for physicians. He regards the arrangement as a potential major breakthrough because "It enables the doctor to have continuing education right in his own home, and pretty much at the hour he chooses. This is crucial today because the modern physician finds it difficult to get into a classroom on a regular basis." Mr. Young explained that the reason that only about fifty doctors can currently pick up the programs at home is not lack of interest but rather the inavailability of cable service in areas where doctors live. Negotiations are being carried on with CATV to ex-

(continued on next page)

JOHN MAXIMILLIAN, left, program manager of Berks TV Cable Co., Reading, discusses a current production with Barry Hoover, center, cameraman, and Sherwood C. Young, executive director of the Berks County Medical Society.

SHOWN DURING the filming of a discussion program are, left to right, John E. Marshall, M.D., Stouchsburg family practice physician; John E. German, M.D., president of BCMS; Arlington A. Nagle, M.D., another Stouchsburg family practitioner; James F. Welsh, M.D., secretary of BCMS; and Sherwood C. Young, executive director of BCMS.

Pennsylvania AMA delegates on camera

PENNSYLVANIA DELEGATES met daily during the American Medical Association convention at breakfast sessions. Shown above are some scenes of the breakfast meetings.

New cable TV use

(continued from page 15)

tend its facilities as rapidly as possible. Currently the county medical society has a set in its building for the benefit of those physicians who cannot participate at home. The Berks CATV station changes the time of broadcast upon request from the society in cases where doctors may be attending meetings at the society building and a rescheduling will enable more physicians to watch, for instance at the close of the meeting.

Other applications of the educational program include plans for a closed circuit arrangement connecting the three Reading hospitals to Berks County Medical Hall. National medical educators would appear in a program originating at Medical Hall and physicians gathered in the hospitals could participate in the dialogue, cutting time required in meetings and still keeping up with study requirements. Negotiations are under way on a plan to give education credits to physicians.

Further information regarding the cable programs may be obtained by contacting Community Medical Cablecasting, 15 Columbus Circle, New York City 10023.

PMS rotogravure

MRS. ROBERT F. BECKLEY, Lock Haven, and PMS President William A. Limberger, M.D., appear above on the occasion of her election as president-elect at the 48th annual convention of the Woman's Auxiliary to the American Medical Association on June 23 in Atlantic City, New Jersey. Mrs. Beckley has served the AMA Auxiliary as bylaws chairman, treasurer and eastern regional vice-president. She is serving currently on the board of the Pennsylvania Citizens' Council and the Planning Committee of the Governor's Conference on Human Resources.

SHOWN BELOW addressing his home county is PMS President William A. Limberger, M.D. at the last meeting of the Chester County Medical Society. Dr. Limberger has visited the large majority of county societies during his year in office.

THE PENNSYLVANIA DELEGATION of the Woman's Auxiliary of the American Medical Association are shown, left to right. Front row: Miss Marcia Gehris, who sang for the memorial service, Mrs. John A. Schneider, Mrs. Robert L. Harding, Mrs. Charles A. Carabello, Mrs. William R.A. Boben, Mrs. David J. Keck, Mrs. Raymond C. Grandon, Mrs. William A. Limberger. Second row: Mrs. John H. Eves, Mrs. Robert F. Beckley, Mrs. Jay G. Linn, Mrs. W. Wayne Babcock, Mrs. Paul C. Craig, Mrs. John M. Wagner, Mrs. Leroy A. Gehris, Mrs. Ralph S. Blasiole. Top row: Mrs. Glenn A. Deibert, Arlene Oyler, Mrs. Axel K. Olsen, Mrs. Victor F. Grieco, Mrs. Frank J. Corbett, Mrs. C. Henry Bloom, Mrs. Spencer J. Servoss, Mrs. Sydney E. Sinclair, Mrs. Morgan F. Taylor, Mrs. William R. Adams, Mrs. P. Ray Meikrantz.

County society 'first'

Environmental award presented to Reading firm

The Berks County Medical Society has presented a special commendation— the first of its kind by a medical society in the Commonwealth— to Carpenter Technology Corp. of Reading for its voluntary efforts over a long period of years to improve the environment.

The company has been seeking ways to continue production, but stop pollution since 1942, when, together with state officials, engineers developed means to prevent contamination of the Schuykill Expressway with raw acid waste.

In 1965 CarTech engineers designed a waste disposal system to prevent pollutants and detergents from entering the Schuykill.

It was then that company officials turned their attention to the problem of removing the "red cloud" of oxide dust, which is not an easy task since 400 different steels and alloys are produced there each year. The solution was found in the development of decontamination equipment which has brought the company in compliance with the state's air quality code, and prompted the county society to make the special award.

Members of the Berks County Medical Society, led by President John E. German, M.D., toured the plant on the day of the presentation, and viewed the new installation known as the "baghouse."

The eight-story structure is 50 by 100 feet, and contains the air filter system that removes iron oxide dust from the atmosphere. Within the building are 2400 dacron bags which provide a filtering surface of more than 5 acres. The system functions, in principal, like a huge vacuum cleaner. Exhaust fans draw dust from the plant's five electric furnaces to the bag house filtering system. A 24-foot-square steel canopy is mounted above each of the furnaces and as iron oxide dust— which is emitted for a few moments during each heat— rises to the canopy, it is drawn to the bag house through large ducts made of self-weathering steel. A supplementary "scavenging" system situated near the roofs draws off furnace emissions that escape the canopies. Control consoles are situated convenient to each furnace to permit close regulation of the system by furnace operators. After the dust is collected in the filtering bags, the bags are emptied into hoppers by a reverse air flow that backflushes one compartment of 120 filtering bags at a time. The dust is then removed by conveyor and bucket elevator to a storage bin from which it is hauled in covered trucks to a remote dumping site.

CarTech President "Mike" Beaver, who accepted the award on behalf of the company, said, "No one mourns the 'red cloud' and we are extremely pleased that it brings us into compliance with the state's air pollution code. We are proud that an organization like the Berks County Medical Society, whose efforts on behalf of the health of this community are well known, has recognized our efforts."

A GROUP of Berks County Medical Society physicians including John E. German, M.D., society president, and Leroy A. Gehris, M.D., PMS trustee from the Second Councilor District, tour the pollution control facilities.

Cancer society grants awarded in Commonwealth

Research grants totaling $252,795 have been awarded to Pennsylvania scientists, physicians, and institutions by the American Cancer Society.

At the Milton S. Hershey Medical Center a two-year grant went to John W. Kreider, M.D., Palmyra, assistant professor of pathology, for study of human resistance to cancer and methods of increasing it through immunotherapy. Walter Ceglowski, PhD., of the University Park department of microbiology, will continue his studies at the medical center of immunity processes directed toward the development of a vaccine to prevent leukemia. Paul J. Fritz, PhD., of the department of pharmacology, will study protein metabolism in normal and malignant cells.

At the University of Pittsburgh School of Medicine, Paul A. Chervenick, M.D., will continue his study of the white blood cell system in an effort to lessen or overcome toxic effects of drug treatment of cancer. Richard Abrams, PhD., Department of Biochemistry, will further his work on basic cell chemistry aimed at determining why normal cells turn into cancer tissue. Irving Lieberman, PhD. school of medicine, has received a grant to support his research program on DNA synthesis. Bernard Fisher M.D., department of surgery of the school of medicine, has been provided funds for evaluating total and radical mastectomy in treating breast cancer.

The girth control pill

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride, N.F.)

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenamena reported include such conditions as rash, urticoria, ecchymosis, and erythema. Gastraintestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T 107/4/71/U S PATENT NO 3,001,910

THE NATIONAL DRUG COMPANY
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Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
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Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps

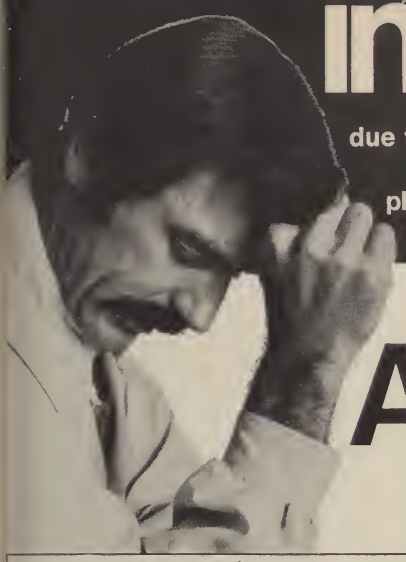
The treatment of

impotence

due to androgenic deficiency in the American male.
The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients—Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



Android®

(thyroid-androgen) tablets

Double-Blind Study and Type of Patient:
100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

REFER TO PDR

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

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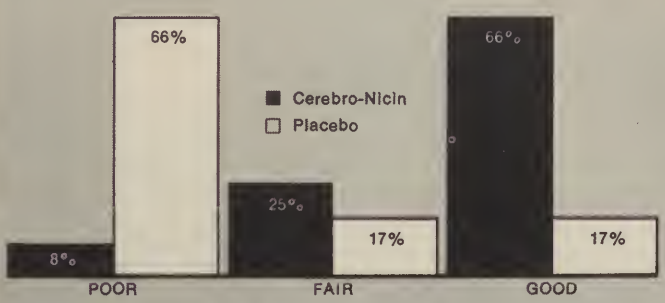
For the treatment of the aging patient

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
1-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir 8 oz. bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

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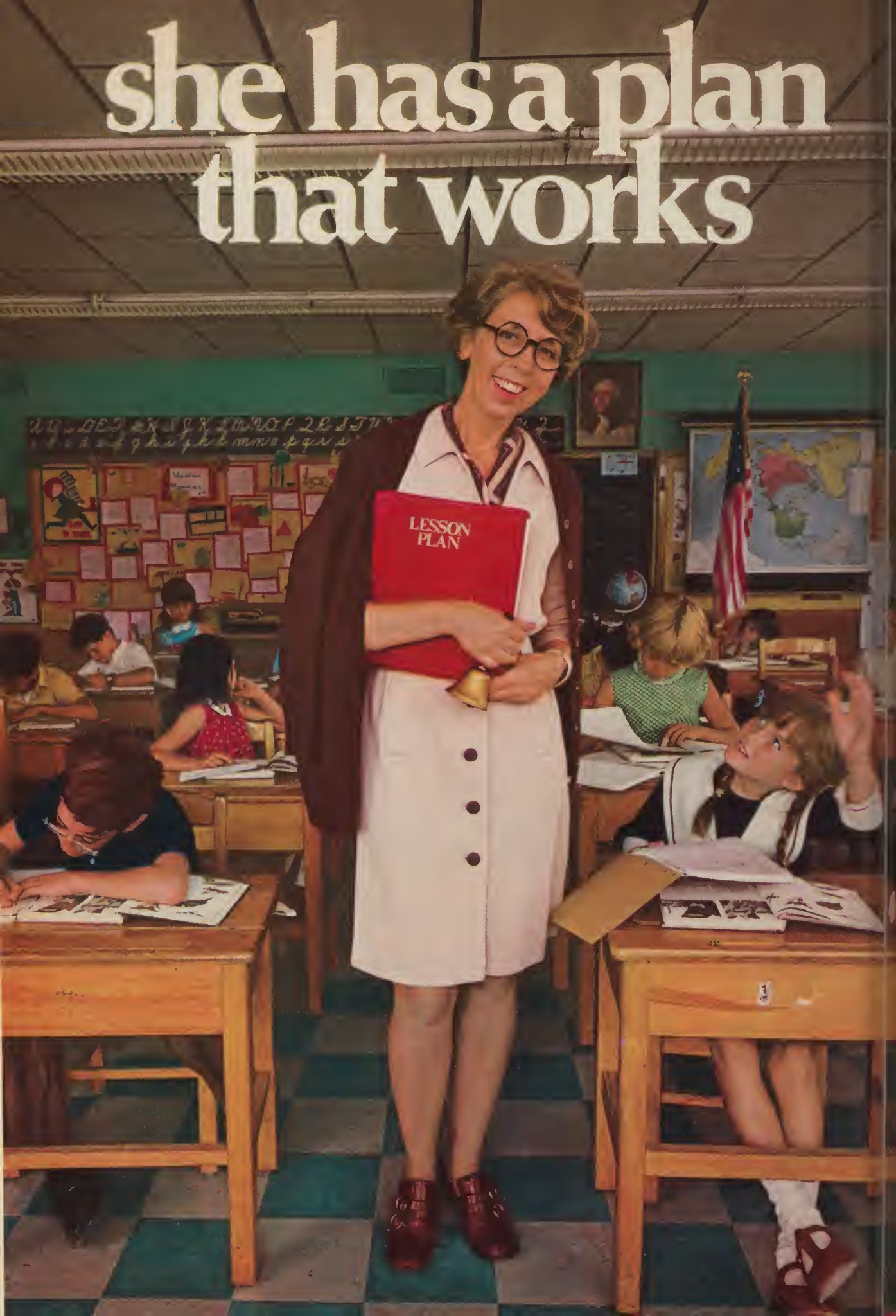
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that works
LESSON
PLAN

She has a plan that works.

She has one plan for the class. And they really respond.

She has another plan just for herself. A medication plan for her hypertension. And she's also responding beautifully.

More than just another antihypertensive, Ser-Ap-Es can be a whole medication plan for living with hypertension.

Does it get good marks for comfort?

Excellent. Because Ser-Ap-Es controls blood pressure effectively, dosage of each component is lower than if prescribed alone, usually minimizing side effects. However, side effects may occur (see prescribing information).

Designed with the kidney in mind?

Hydralazine maintains or increases renal blood flow.

And the brain too?

Hydralazine also relaxes cerebral vascular tone. And reserpine has beneficial calming action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

Practical on a teacher's salary?

Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits...

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

C I B A

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

a plan for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

INDICATIONS: All cases of hypertension except the mildest and the most severe.

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

Hydralazine: Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Reserpine: The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydralazine: Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

Hydralazine: Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Reserpine: Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

Hydralazine: Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE: One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

SUPPLIED: *Tablets* (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

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Division of CIBA-GEIGY Corporation
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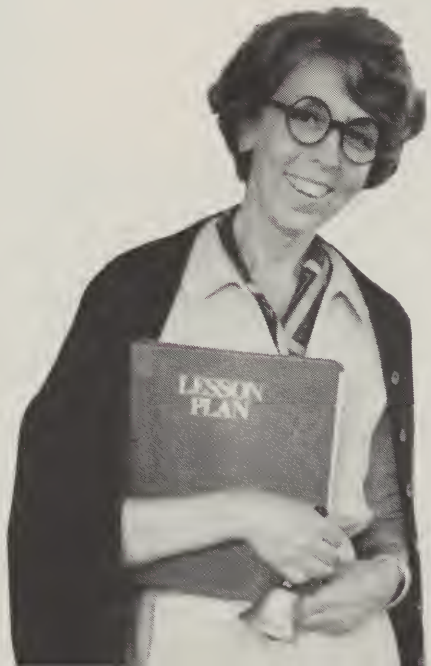


she has a plan that works for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

CIBA

m.d.'s in the news

An associate in dermatology at the University of Pennsylvania's School of Medicine, **Lawrence Charles Parish, M.D.**, was appointed historian of the American Academy of Dermatology.

Lehigh Valley's first forensic pathologist will be **Isidore Mihalakis, M.D.**, Bethlehem. Included in his duties will be determining the cause of injury and death in disability and criminal cases. He was formerly forensic pathologist for the chief medical examiner for the state of Maryland.

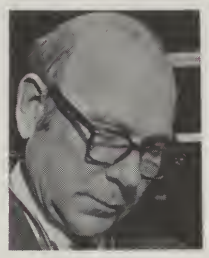
The Distinguished Teacher Award at Harrisburg Hospital's Doctor's Day was given to **Herbert S. Bowman, M.D.**, and **Harold R. Schumacher, M.D.**, hematologists. Dr. Bowman is chief of inpatient and outpatient services in the hematology section of the department of medicine at Harrisburg Hospital, a fellow of the department of internal medicine at Jefferson Medical College, and an associate professor of medicine at Hahnemann College in Philadelphia. Dr. Schumacher is senior associate hematologist, department of medicine, section of hematology, at Harrisburg Hospital.

The Pennsylvania Academy of Ophthalmology and Otolaryngology has announced the election of new officers and directors. **Joseph P. Atkins, M.D.**, Wynnewood, will serve as president. He is clinical professor and chairman of the department of bronchology, esophagology, and laryngeal surgery, division of graduate medicine, at the University of Pennsylvania and clinical professor of broncho-esophagology at the University of Pennsylvania School of Medicine. **C. William Weisser, M.D.**, Pittsburgh, chief of staff in ophthalmology at St. Francis Hospital in Pittsburgh, was selected as president-elect. Vice-presidents are: **Harry S. Weaver, Jr., M.D.**, Philadelphia; **Clyde B. Lamp, M.D.**, Pittsburgh; and **Woodrow D. Schlosser, M.D.**, Philadelphia. **Albert F. Cleveland, M.D.**, Drexel Hill, will serve as treasurer. New directors are **Donald B. Kamerer, M.D.**, Pittsburgh, **David A. Cope, M.D.**, Reading, and **William H. Annesley, Jr., M.D.**, Upper Darby.

E. Raymond Place, M.D., has been honored for 34 years of service by the Skippack Lions Club with the presentation of a plaque. He was also recognized for his assistance in organizing the Skippack Ambulance Corps.

The Milton S. Hershey Medical Center of Pennsylvania State University has announced the appointment of **Richard M. Bergland, M.D.**, as professor of surgery and chief of neurosurgery in the College of Medicine. A fellow of the American College of Surgeons, a member of the American Association of Neurological Surgeons, the Neurosurgical Society of America, and the Research Society of Neurological Surgeons.

DR. BERGLAND



DR. RUSH

A Topton physician, **William O. Muehlhauser, M.D.**, was elected to serve on the board of trustees at Muhlenberg College. Dickinson College has selected **Alexander Rush, M.D.**, Philadelphia, as a member of its board of trustees. Dr. Rush is on the faculty of the University of Pennsylvania School of Medicine and chief of gastroenterology at Pennsylvania Hospital. He is the great grandson of Dr. Benjamin Rush, a leading Philadelphia physician of his day and a signer of the Declaration of Independence.

The new president of the Pennsylvania Allergy Association is **Martin A. Murcek, M.D.**, Greensburg. **Gilbert A. Friday, M.D.**, Pittsburgh, has been selected as president-elect.

Thomas J. Natoli, M.D., Norristown, will serve a ninth term as president of the Child Development Center's board of directors.

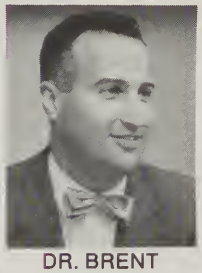
Harry Boretsky, M.D., Pittsburgh, has been elected president of the Pennsylvania Society of Anesthesiologists. **Harry Wollman, M.D.**, Narberth, is president-elect, while **Louis J. Hampton, M.D.**, Hanover, will serve as secretary, and **William D. Stewart, M.D.**, Allison Park, as treasurer.

William F. Donaldson, M.D., Pittsburgh, has been named chairman of the Medical Advisory Committee to the Hospital Planning Association of Allegheny County to succeed **J. Everett McClenahan, M.D.**, who is retiring.

Elected to lead the University of Pittsburgh Medical Alumni Association are: **Drs. James A. Rock**, Johnstown, president; **Paul L. McLain**; **Howard A. Mermelstein**; **Robert S. Totten**; and **Richard H. Horn**, president-elect, vice-president, secretary, and treasurer respectively, all of Pittsburgh.

New medical director of the Penn-Jersey Regional Red Cross Blood Program is **William C. Sherwood, M.D.**, Cherry Hill, N.J., who succeeds **Robert T. Carroll, M.D.** He is a member of the Cardeza Foundation for Hematologic Research and assistant professor of medicine at Thomas Jefferson University.

The new chief of pediatric surgical service at Thomas Jefferson University hospital is **Louis F. Plzak, Jr., M.D.** He was formerly assistant professor of surgery at Harvard Medical School and chief of the cardiac surgical clinic of Children's Hospital Medical Center, Boston.



DR. BRENT

DR. PLZAK

Jefferson Medical College has announced the appointment of **Robert L. Brent, M.D.**, Huntingdon Valley, as visiting lecturer at Fitzwilliam College, Cambridge University, England. Dr. Brent is chairman of the department of pediatrics at Jefferson. Besides lecturing, he will be conducting research at the biology laboratories at Cambridge and will present a paper at the first meeting of the European Teratology Society.

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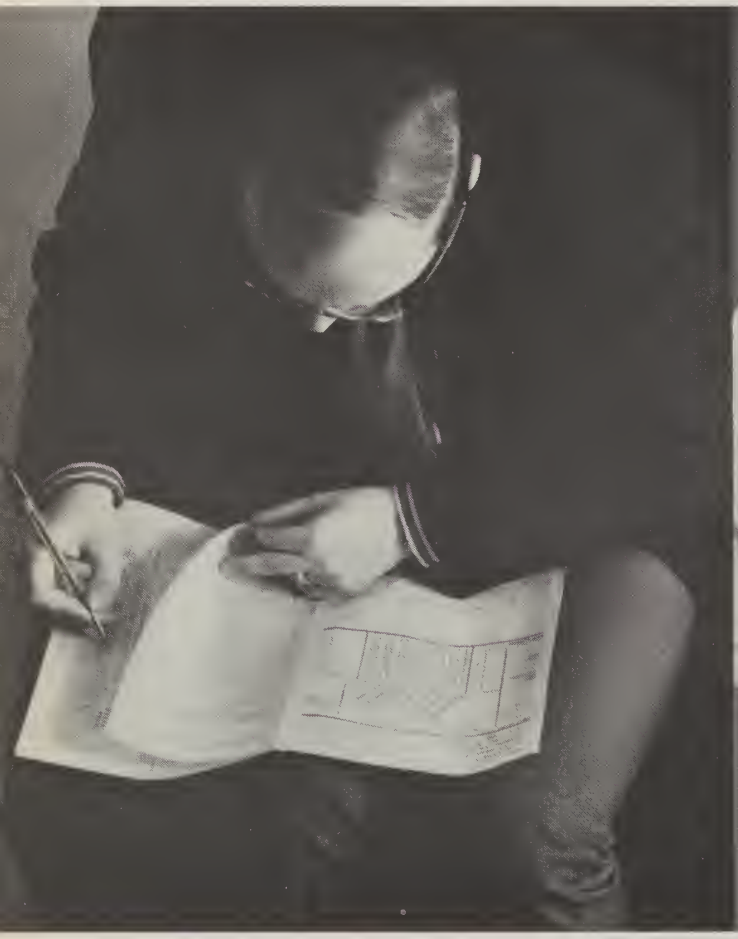

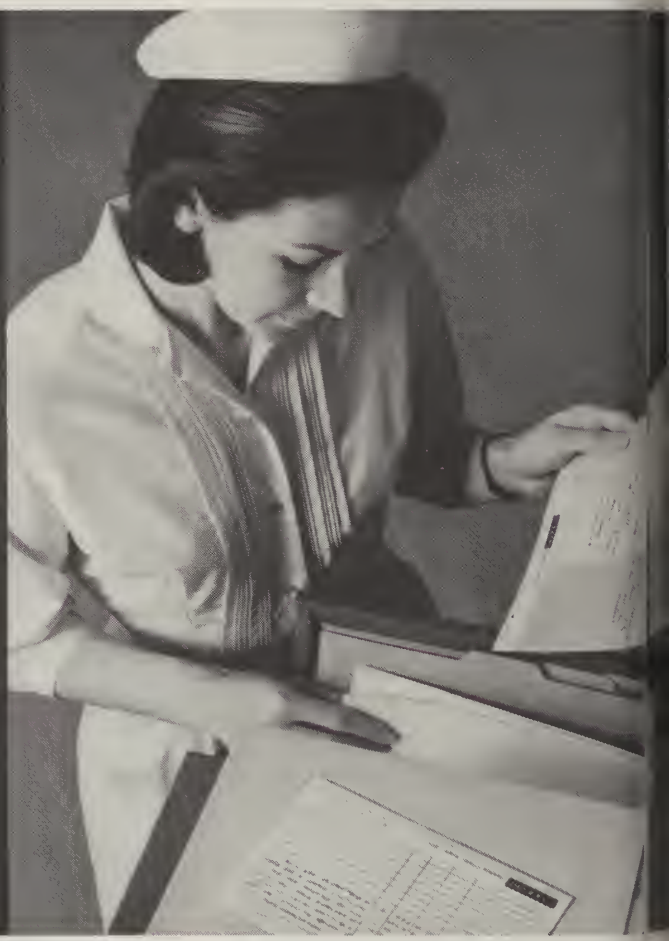

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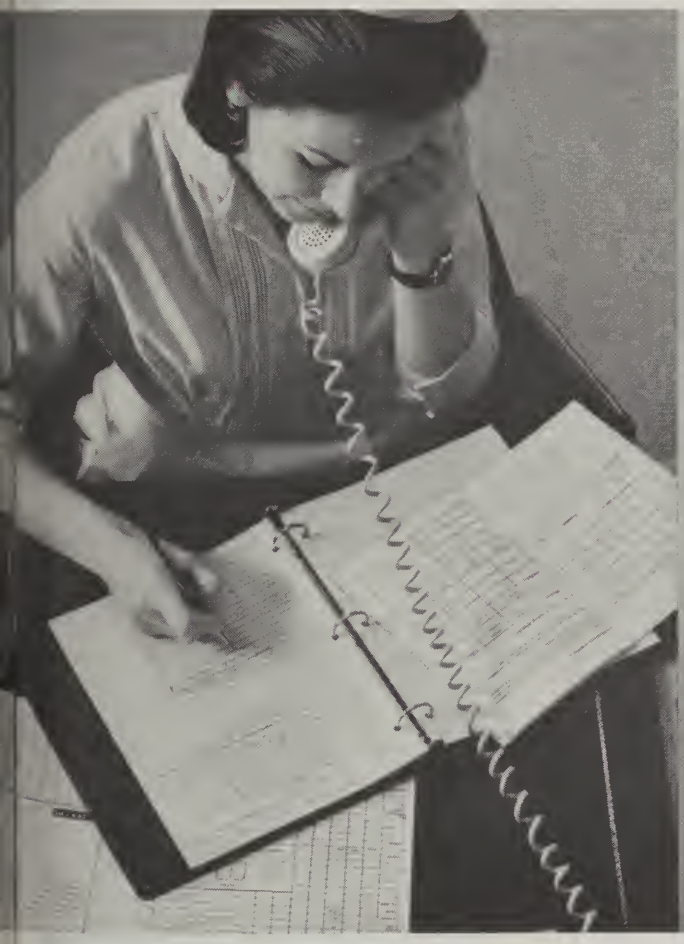

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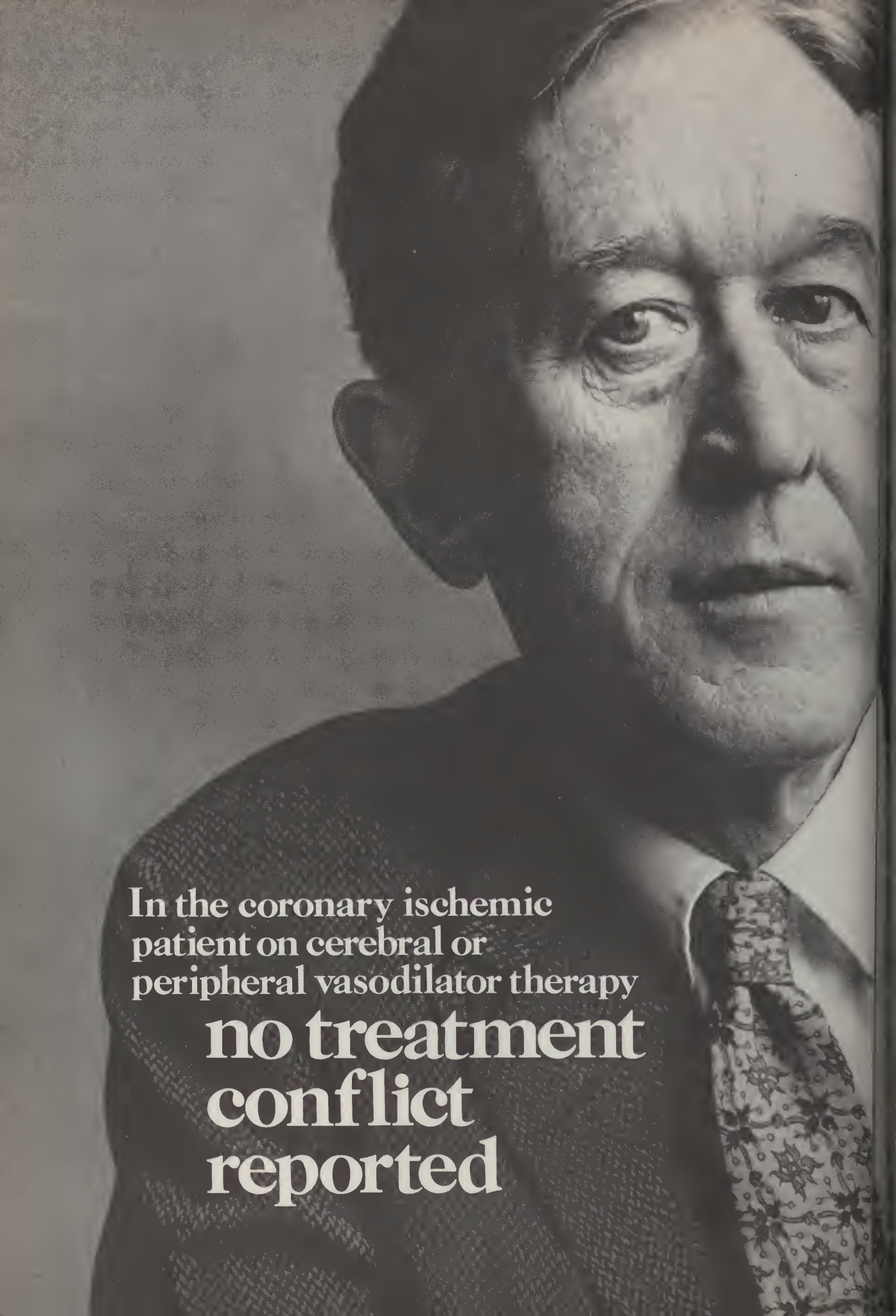
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Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[1-4] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[2,4] and observation of clinical improvement.[1,3]
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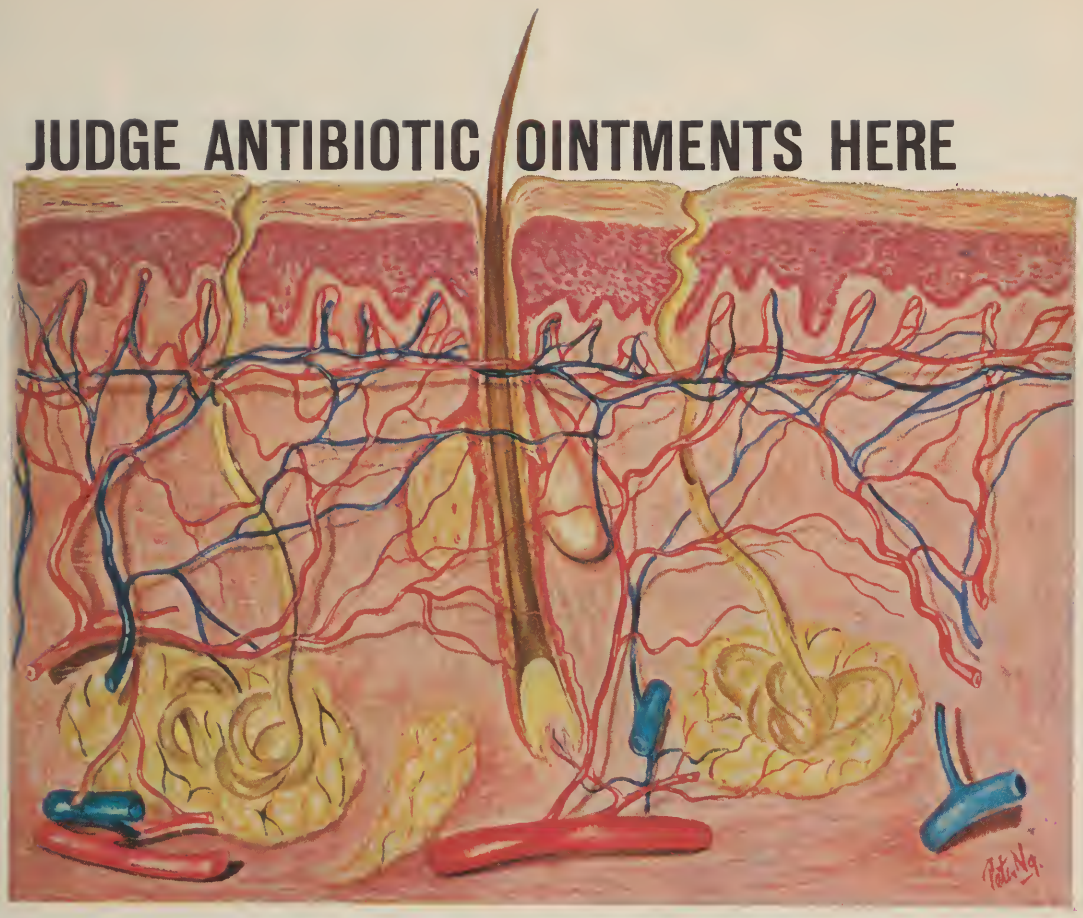

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INDICATIONS Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily icated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with te episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities ilable, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recomnded in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic creatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure drome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital y be indicated. ■ CONTRAINDICATIONS Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retent, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH te (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ PRECAUTIONS Administer with caution in the presence of incipient ucoma. ■ SIDE EFFECTS The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving o 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. rred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic gs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsis, and rash. ■ DOSAGE The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one let three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual ient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum uired to maintain symptomatic relief. ■ SUPPLY Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved R/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue lets engraved AHR/2 in bottles of 100 and 500.

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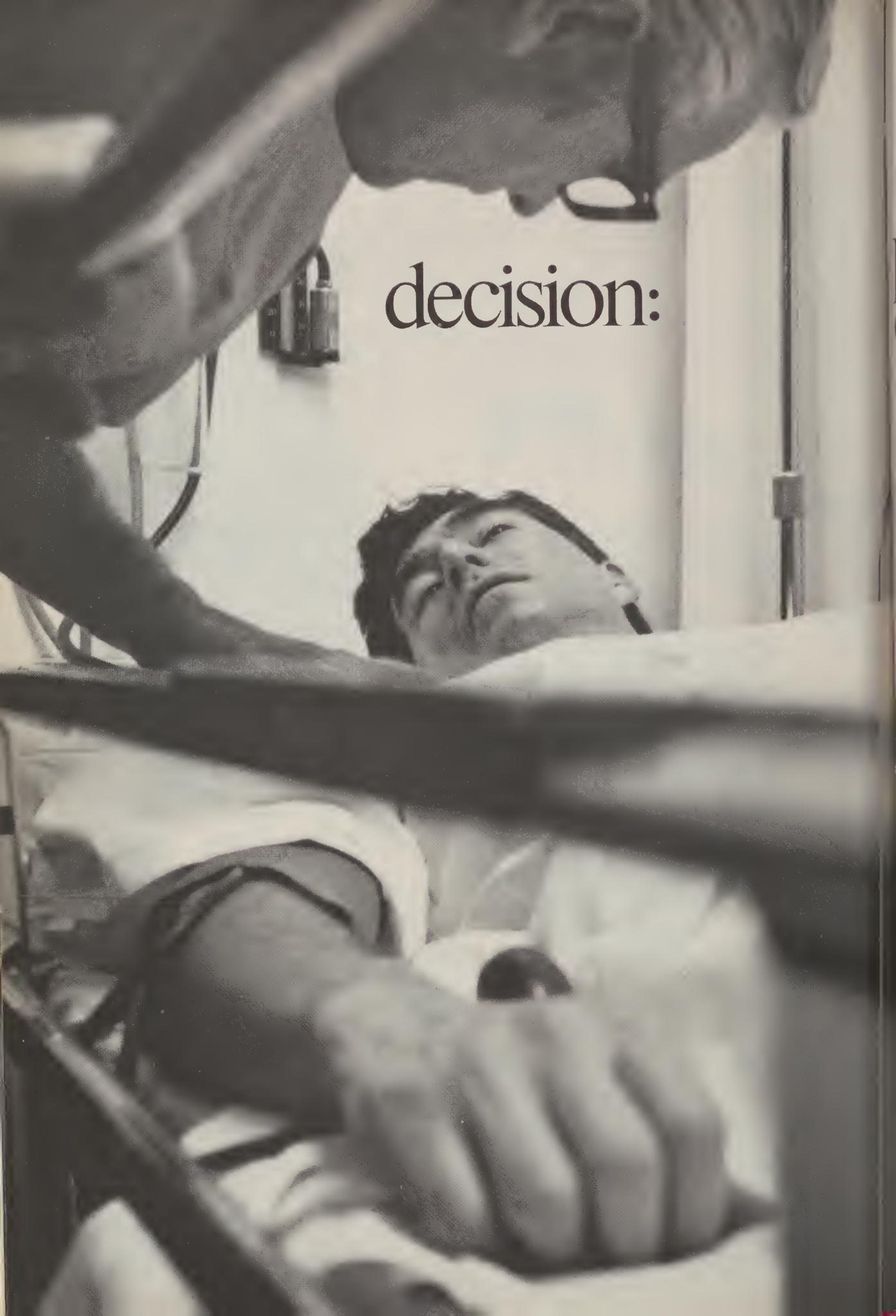
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1.5 to 3 Gm. daily successfully treats many moderately severe infections*

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*due to susceptible organisms

Special Recommendations
Before Administration of Loridine
1. Demonstrate causative organism's sensitivity to the drug.
2. Determine patient's renal status. Loridine is *contraindicated* in patients with azotemia.
During Administration of Loridine
1. Maintain proper hydration.
2. Monitor renal status—urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously in conjunction with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit daily dose to 4 Gm. maximum (up to 100 mg. per Kg. in children—not to exceed adult dosage). Many serious infections due to sensitive organisms will respond to doses of 1.5 to 3 Gm. daily.
5. In patients who have impaired renal function (without azotemia) *before* treatment, reduce daily dosage, depending on degree of impairment.
6. In patients who develop impaired renal function *during* treatment, discontinue therapy with Loridine.

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Loridine®
CEPHALORIDINE

Please turn page for prescribing information.

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (*see* Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Loridine®
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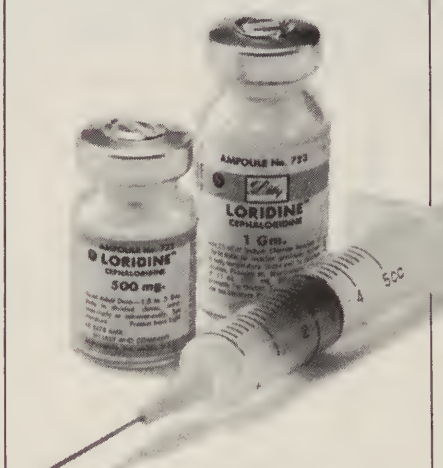

Usual adult dosage, 1.5 to 3 Gm. daily, is effective against many moderately severe infections due to susceptible organisms.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine® (cephaloridine, Lilly) before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult dose) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as acteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

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PENNSYLVANIA MEDICINE special report

The physician and air pollution

KATHARINE BOUCOT STURGIS, M.D., M.P.H.
Philadelphia

Editor's Note

Dr. Sturgis is a member of the Pennsylvania Medical Society's Commission on Environmental Health, immediate past president of the Delaware Valley Citizen's Council for Clean Air and of the American College of Preventive Medicine. Her expert testimony at federal hearings was helpful in changing the weak proposals for air quality control in the Commonwealth to the strongest regulations in the nation.

Two decades have passed since air pollution was recognized as neither an isolated Los Angeles phenomenon nor one with effects limited to acute, sporadic episodes. The medical profession, as aghast as the general public at reports from Donora in 1948, relaxed when time went by without a recurrence. This was but the lull before the storm— appreciation that levels of pollutants were increasing and were distributed on a world-wide scale.

As chemotherapy reduced mortality from tuberculosis, chronic bronchitis, emphysema, and lung cancer presented increasing problems. While smoking was correctly indicated as a major cause of these three grave respiratory diseases, epidemiologic studies suggested that air pollution plays a role in etiology and exacerbation. In contrast to control of smoking which is a matter of self-discipline, control of community air pollution requires cooperative community action. The medical profession has obligations in this field— for patients, especially those most affected, those with cardiorespiratory disease, and to the community which looks to its physicians for authoritative statements on the health effects of air pollution, counseling, and anticipatory guidance in healthful living. There are not enough physicians to care for the sick among our burgeoning people; it behooves us to do battle with the causes of illness in order to stave off the neverending stream of incapacitated.

All major acute air pollution episodes have occurred in the fall of the year at the time of atmospheric inversions— from the Meuse Valley Smog of December, 1930, to the Eastern Seaboard Air Pollution Episode in the fall of 1966. So it seems wise to provide high risk patients with instructions in the late summer or early fall. These might be, for example:

"GET SET" INSTRUCTIONS BEFORE THE OCCURRENCE OF AN AIR POLLUTION EPISODE

I. *Avoid Exposure to Irritants*
   A. Don't smoke.
   B. Avoid being in a room in which others are smoking.
   C. Avoid fumes at work, from automobile exhaust, frying, etc.

II. *Provide at Least One Room at Home with Air-Conditioning*
   Keep filters clean and units in proper working order.

INSTRUCTIONS DURING AN AIR POLLUTION EPISODE

I. *Go or Remain Indoors with Windows Closed.*
II. *Turn on Air-Conditioning*
III. *Avoid Exercise*
IV. *Keep Hydrated*
   A. Drink adequate water or fruit juice (you are drinking inadequate water if your urine is orange colored).
   B. Remember that coffee, coke, etc., remove instead of adding fluid.
   C. Avoid alcoholic beverages because they are "drying."
V. With the above program, no untoward effects from air pollution should ensue. If new or unusual symptoms occur, contact your physician.

So far as the physician's role in the community is concerned, he should set an example by not allowing leaf nor rubbish burning on his premises, keeping his car in good running order, and not smoking. It is absurd to appear publicly to speak against air pollution while smoking; such behavior contradicts any sincerity in statements made against pollution.

It is wise to join those local, state, and national organizations most active in fighting for clean air. These may be the Tuberculosis Associations. In the vicinity of Philadelphia,

the Delaware Valley Citizens' Council for Clean Air is very aggressive. Such memberships serve a two-fold purpose; they keep the physician informed of trends, legislation, hearings, problems, etc.; while they assure the public that physicians are vitally interested in restoring our environment. So far as possible, the physician should assume a leadership role by serving on boards, accepting offices, testifying at hearings, etc. Most of our Pennsylvania County Medical Societies have Air Pollution Control Committees. I was proud, at the King of Prussia public hearing before the Pennsylvania Air Pollution Commission on September 10, 1969, that Dr. Charles Myers testified for the Pennsylvania Thoracic Society as Chairman of its Advisory Committee on Air Pollution and as Chairman of the Committee on Environmental Health of the Luzerne County Medical Society and that I testified as Chairman of the Philadelphia County Medical Society's Committee on Air Pollution Control. I am sure that other members of our Society testified at the Pittsburgh hearing. Pennsylvania passed levels for particulates and sulfur dioxide which allow a factor of safety and, as physicians, we can feel that we contributed toward this wise decision.

To appear regularly at meetings of Air Pollution Control Commissions is not only to keep informed but to reassure the community of our concern. To be willing to testify against polluters after conscientious investigation is to bring the power of our profession against the uninformed or willfully negligent. For instance, in November, 1969, Dr. Jar Lieben alerted me to the "snowstorm" of asbestos taking place in central Philadelphia due to the relatively new use of asbestos spray fireproofing in the construction of a high rise office building. I alerted the Air Management Service of the Philadelphia Health Department. After suitable study and exploration of the possibility that a wet slurry might be safer than the dry material, the city of Philadelphia refused to issue licenses for building construction in which asbesto spray fireproofing was to be used because of the potentia for lung cancer and mesothelioma in construction workers the public, and future occupants of such buildings. Nev pertinent regulations are in process of legal adoption. Thes would ban the use of asbestos spray fireproofing i Philadelphia. Dr. Norman Williams, professor of preventiv medicine, occupational medicine, of the Thomas Jefferso University, and I participated in drafting these regulations.

An alerted citizenry looks to us, physicians, for leade ship. We should not fail them!

Boards of medical licensure say:

Physicians should not tolerate licensed cultism

Some recent estimates place the number of chiropractors practicing their cult in the United States at about 35,000. Others suggest that there are less than half that number. In contrast to the several hundred thousand physicians who practice scientific medicine, the smaller number of chiropractic cultists might appear to reduce their significance. Yet, the number of patients consulting chiropractors each year may approach three million. Again, not a large number when compared with the many millions who seek and obtain high quality medical care based on the scientific method. But among those receiving such cult-based therapy are many who will delay seeking adequate effective medical care until it is too late. And others will sustain physical injury during applications of the "chiropractic method."

The theory of chiropractic has never been supported by objective evidence and it has been fully refuted by medical science. Yet, chiropractic, the only existing cult which still constitutes a significant hazard to the public, continues because of the tolerance of many otherwise conscientious physicians, as well as powerful political pressure-groups.

The recent report of the Health Manpower Commission* recognizes that ideally chiropractic statutes should be repealed to remove the cult's shield of legitimacy. However, the report indicates that such repeal would be unlikely at this time *because of the power of the chiropractic lobby!*

That report could have added that *the* lobby must not be considered a single unit, waiting patiently for someone to challenge the legal sanction given the cult by licensure in all but a few jurisdictions. For highly skilled lobbyists—representing the chiropractic cult— now are reported to be active in state legislative assemblies across the nation. An legislative bill, no matter how remote its title may seem t be, offers such lobbyists a vehicle capable of legally increa ing the breadth of the definition of the cult. For chiropra tors have proclaimed widely their opposition to constrai upon their practice by statutory definition! It would appe that chiropractic has chosen to follow the precept that th best defense is a strong offense. And meanwhile, back at th community medical workshop level, physician tolerance chiropractors continues.

Thus, when physicians, medical associations and boar of medical examiners tolerate the continued survival of th cult, they bear some of the responsibility for diagnos delayed until it may be too late, for physical injuries fro application of the "method" and the by-product of th practice, an ever-more-powerful chiropractic lobby.

Therefore, board members and other physicians must a sume a more militant posture against licensed cultism, th unscientific practice of chiropractic techniques. The goal clearly in view, the ultimate repeal of every chiropract practice act in the nation. But, can it be accomplished? Ce tainly! However, it will take time and try the patience many. Nonetheless, the stakes are high and physicians longer can afford the luxury of overlooking their respon bility for the protection of the health of the public.

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Federation Bulle
May 1971

* Report of the National Advisory Commission on Health Manpow 1967. U.S. Government Printing Office, Washington, D.C.

William L. Estes, Jr., M.D., Bethlehem surgeon and past president of the Pennsylvania Medical Society, died on June 15, 1971, at the age of 86, having devoted more than sixty-two years to the practice of medicine and to numerous other community services.

He graduated from Lehigh University in 1905 and from Johns Hopkins University Medical School in 1909. After interning at Johns Hopkins and serving a fellowship at Mayo Clinic, Rochester, Minn., he returned to Bethlehem in 1912 where he joined the staff at St. Luke's Hospital, which his father had founded in 1872. He was chief of surgery at St. Luke's from 1930-1950.

In 1942 he was elected to the American Medical Association House of Delegates, which he continued to serve for eighteen years. Dr. Estes was elected president of the Pennsylvania Medical Society in 1945. He also served at various times as president of the Northampton County Medical Society, president of the American Association for the Surgery of Trauma, and president and chairman of the Board of Governors for the American College of Surgeons.

He was a lecturer in surgery at the Graduate Medical School of the University of Pennsylvania from 1945 to 1954. Named chief of surgery emeritus at St. Luke's in 1957, he was also its first medical education director in 1959.

Together with fourteen other physicians, he helped to found, and was named first medical director of the Diagnostic Clinic in Bethlehem in 1957.

Dr. Estes' interests went far beyond the medical field. He was cofounder of the Bethlehem Chamber of Commerce, a trustee of Lehigh University, and a president and director of the Bethlehem Bach Choir for many years. In 1956 the Bethlehem Community Chest honored him with its Outstanding Citizenship Award.

In addition to his service to his local community and to state and national medical societies, he was a member of the International Surgical Society, the American Association for the Advancement of Science, the American Board of Surgery, the Philadelphia Pathological Society, and the American Diabetic Society.

His record of service stands as his memorial.

'Let George say it'

A time for unity

GEORGE A. ROWLAND, M.D.
Millville

The AMA is in trouble. Dues are high and rising. Young doctors think the organization has its head buried in the past, and refrain from joining. Older physicians think it is remote from their problems and it has sold out to hippies and wild-eyed radicals. They find it easy to rationalize saving the cost of dues.

This is a dilemma. It is particularly unfortunate that it occurs when unity among physicians is so vital to all. Little more than 50 percent of practicing doctors belong to the national organization today. If this trend goes on and becomes worse it is conceivable that the AMA may become entirely impotent. With so much falling off, it is becoming less believable for organized medicine to claim to represent doctors in dialogues with government and other groups. Practically all physicians belong to specialty organizations, but without the unifying effect of a common allegience these tend to be at odds. The voice of medicine through many mouths would be diluted and weak.

It is easy to fault the unfaithful in this case. They should realize the difficulties faced by the brass in dealing with antagonists of great power. Even the country's president, who was greeted so warmly by the House of Delegates in Atlantic City, was less than open-armed. While he expounded the Administration proposal, he very pointedly made no mention of the Medicredit Plan, that health insurance program worked out by AMA leaders at so much cost and effort.

The officers and staff of the AMA are selflessly doing their best for doctors and patients. Some of their actions, like the progress of Medicredit, have been almost superhuman; but the average citizen believes that the AMA is run by black-hearted villains and he seems to have convinced the average M.D. that this is so.

Some splendid efforts to tell the membership of the AMA's good works have been made. It is hard to see how publications like "Todays Health Guide" and "Drug Evaluations" can be overlooked. Apparently a deeply engrained habit of distrust, plus a natural tendency to thrift when the time comes to pay dues, is too strong a combination. It is not enough just to do good for the membership, the membership must believe that the leadership is good.

Organized medicine has crawled out of the primordial ooze. It must now sell itself to the doctors of America. The alternative is disolution and chaos, in the course of which others will take charge. Medicine will suffer greatly as physicians will drop to the level of technicians third-grade. Sometime later they may attain a degree of control again, but only when, like semi-skilled workers, they are unionized and make use of the strike.

Before it is too late, the AMA needs to alert its members to the true dangers they face and the benevolent qualities of their association. Physicians who, like the Bourbons, think that all men will honor them forever need to learn the truth. They must assume their part of the responsibility to make this a quality profession that deserves its high place. If they do not, leadership must share the blame for inadequately presenting the facts.

A review of rubella guidelines

The following statement, adopted in December 1970, was prepared by The National Council of Obstetrics-Gynecology and The American College of Obstetricians and Gynecologists with the advice of authorities in pediatrics and virology. These recommendations are subject to change as further knowledge and experience are accumulated.

STATEMENT ON RUBELLA VACCINATION AND CONTROL OF RUBELLA VIRUS INFECTION IN WOMEN OF CHILDBEARING AGE

In the adult female population approximately 85 percent to 90 percent of individuals are thought to have a high level of naturally acquired immunity and only 10 to 15 percent are considered to be susceptible to rubella infection.

The current mass vaccination program, directed at prepubertal children, seeks to eliminate or reduce wild virus rubella. However, at the present, the duration of immunity acquired from vaccination remains in question. Available data indicates that antibodies persist at least for four years, the period of time the present vaccine has been available. It is possible that adult women vaccinated in childhood may be susceptible and might acquire an active rubella infection. This latter infection may express itself subclinically with only arthralgia or mild malaise and hence may go undetected. Should this occur in pregnancy, the consequences to the fetus may be comparable to a rubella infection in the absence of previous vaccination. Whether or not the vaccine per se has any teratogenic capacity is unknown, and such knowledge may not be available for a long time.

The following recommendations pertain to women in the childbearing age:

- Vaccination of the pregnant woman is contraindicated under all circumstances.

- No woman in the childbearing age should be routinely vaccinated unless it can be determined that she has a negative hemagglutin-inhibiting antibody titer (HAI) and thus is susceptible to rubella.

- If a woman in the childbearing age has a negative HAI test, she may be vaccinated if there is reasonable assurance that she will not become pregnant for a period of at least two months.

- All pregnant women, even those vaccinated, should be routinely tested for HAI antibodies at the first prenatal visit. If a question of rubella exposure arises in the patient with a negative test, a repeat blood specimen can be tested four weeks after the presumed exposure. A seroconversion from a negative to a positive test is indicative of a recent infection and raises the question of termination of pregnancy.

- Postpartum patients who had negative HAI tests prenatally can be vaccinated in the immediate puerperium if there is reasonable assurance that they will not becon pregnant for at least two months.

- All Patients seen in premarital examinations who ha negative HAI tests should be routinely vaccinated if there reasonable assurance that they will not become pregnant f at least two months.

- Patients tested in a reputable laboratory should be given card verifying the results of the test.

- Termination of pregnancy should be considered in woman who initially tests negative for rubella antibo (negative HAI) and who has a seroconversion after presumed exposure to wild type virus.

- There is no conclusive evidence that the attenuated vir (vaccine virus) is transmitted from person to person. Henc termination of pregnancy is not considered in women wh have been exposed to recently vaccinated children or adult

- The administration of human immune gamma globulin t pregnant women who have been exposed or are sufferir from a rubella infection is *not* usually recommended. The is little evidence that any significant prophylactic effe may be expected from gamma globulin in persons who a infected with a rubella virus.

**The hemagglutination-inhibition test becomes positive within three days about two-thirds of cases and in nearly all cases within four to seven da after onset of rash. It is a relatively reliable test and highly useful for clinic purposes.*

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recautions. Since drowsiness may occur with the se of this drug, patients should be warned of that ossibility and cautioned against driving a car or perating dangerous machinery while taking this rug.
Patients should also be cautioned that their re-sponse to alcohol may be potentiated.
Since suicide is an inherent risk In any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.
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Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.
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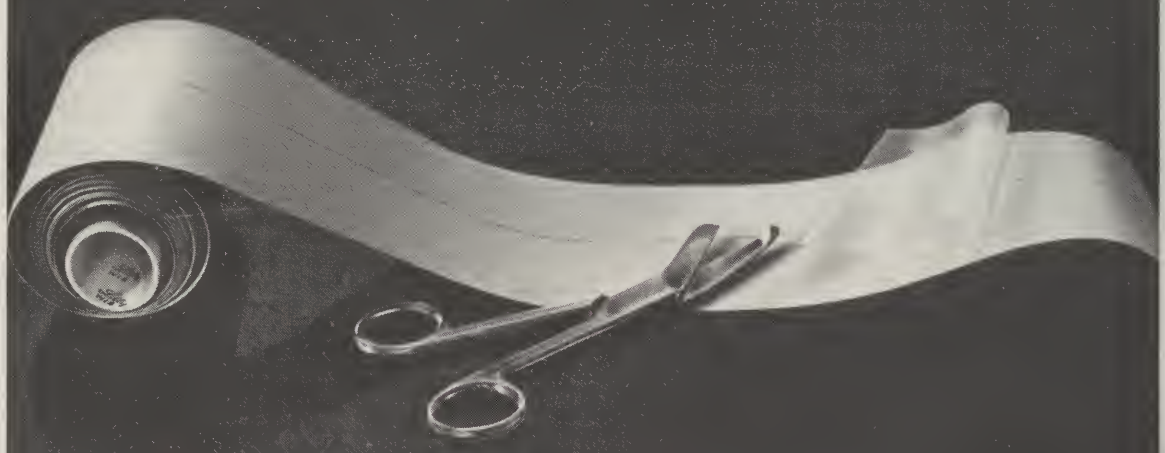

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Surgical Treatment of Pressure Sores

STEPHEN J. HERCEG, M.D.
ROBERT L. HARDING, M.D.
Harrisburg

IT IS ONLY IN the past 25 years that the subject of paraplegia and quadraplegia received any more than passing attention from the medical profession. World War II, by creating a large number of patients with spinal cord injuries, made the problem important enough to be given consideration, even though it had been present for generations.

Pressure sore or ulcer was described in the literature about 1915. Up until this time, it had been treated mainly by conservative means. In 1938, John Staige Davis recommended flap coverage to provide a well padded tissue over bony prominences. This was a daring recommendation to make and carry out in the face of a grossly-contaminated wound, with no antibiotic coverage available and with less than widespread use of blood transfusion. The groundwork, however, had been laid for surgical treatment of this problem. Little more surgical progress was made until 1945. During World War II the value of penicillin in infection was demonstrated and more flap coverage of ulcers was used. Wide use of surgical treatment followed in military and Veterans Administration hospitals, giving much experience and establishing principles for the care of such patients.

Another breakthrough in this field was the association of paraplegia, immobilization, and nitrogen imbalance in this type of patient.

Mulholland made this finding in 1943. Greely, Kostrubala, Blocksma, and Griffith from Chicago recommended in 1947 and again in 1949 the removal or contouring of bone prominences at the time of flap coverage. This improved their success rate postoperatively by about 40 percent. More radical excision of bone, even to ischiectomy and high thigh amputation was recommended by Georgiade and Pickrell from Duke, by Case and White from Pittsburgh, and by Spiro and Hardy from Texas. We feel that the middle course is, however, the best approach to this problem. Useless removal of supportive bone and limbs, to make an already paralyzed individual more unstable, or to make rehabilitation in this individual more complicated, should definitely be avoided.

Figure 1

A: (left) *This case illustrates a direct abdominal flap to an elbow which was the site of a severe olecranon bursal infection and subsequent slough. This problem is also seen in quadriplegics. B:* (right) *Healed flap of the elbow.*

Etiology

In discussing the etiology of this problem, one single factor is paramount and that is pressure. An effort has also been made to change the term from the conventional decubitus ulcer to "pressure sore," which describes the lesion more accurately. These lesions can occur on the naterior ribs, the occiput, the anterior iliac spine, as well as in the more common sacral, ischial or trochanteric areas.

Pressure on an area of skin lasting anywhere from two to twelve hours is enough to initiate the vicious cycle of ischemia which eventually leads to ulceration. Contributing factors in the creation of pressure sores in paraplegic patients are very important. If the nutritional status of the patient is lowered by any means, such as prolonged infection, starvation, or inanition. This contributes to the formation of pressure ulcers. Actually a disturbed metabolic state does not have to exist prior to formation of pressure sores. We have all seen the relatively healthy young person sustain an injury that renders him paraplegic or unconscious, and within a few days pressure ulcers are present despite good nursing care. Yet we have seen other patients who never develop ulcers despite poor care.

Gross Pathology

Even though one thinks of pressure ulcers or sores more often in terms of chronicity, they also have acute phases. Any erythema, cyanosis of the skin, blister formation, local swelling, or superficial necrosis is considered the acute form of pressure sore. The process of ulceration can be reversed at any stage of development up to superficial necrosis of skin by relieving

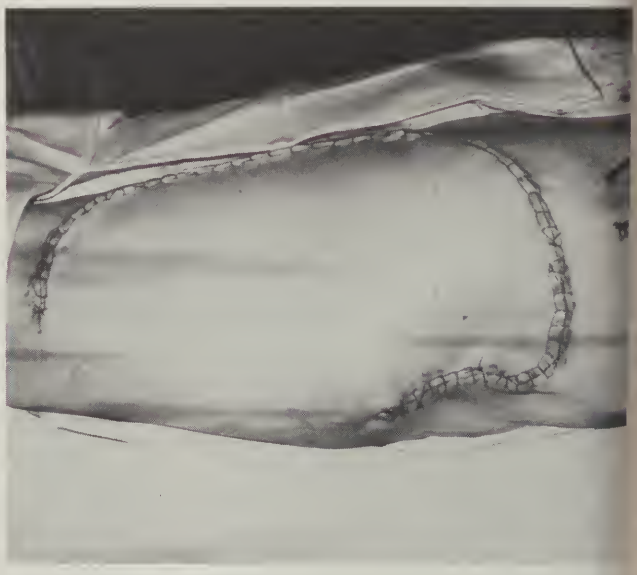
Figure 2

A: Paraplegic female patient who had entire left head and neck of femur removed but has a persistent large ischial ulceration.

B: Final appearance after closure of the ulcer. Wide undermining of buttock and thigh flap and muscle interposition was used.

Figure 3

A: Diagram for excision of trochanteric ulceration and design of anteriorly based 2:1 flap.



B: Completed procedure showing advanced tissue so as close bed of flap rather than skin graft.

pressure, drying the area, or treating local infection with local antibiotic ointments.

The chronic form of pressure ulcer is the large area of ulceration seen over some bony parts of the body. There is deep destruction of tissue including skin, fat, fascia and muscle, with exposure of bone and synovial membrane. The ulcer is usually undermined and has serous or bloody, foul-smelling material draining from it, depending on past care and hygiene of the patient. This large chronic ulceration began with a minor pressu point, where healing and repeat breakdown occurred until it destroy a large area. Some attempt at heali can be evidenced by marginate s and thin shiny epithelium. We do r believe that this ulcer can heal spon

Figure 4

A: *Lateral foot ulcer in patient with meningocele.*

B: *Diagram for rotation flap of dorsum of the foot to lateral foot and plantar surface.*

C: *Flap transposed and bed covered with a split thickness skin graft. Long sutures are for Stent Tie-over dressing.*

D: *Final result shows good tissue on lateral foot and plantar surface.*

neously and permit a reasonable rehabilitation program to be carried out at the same time. The depths of the wound have luxuriant red granulations with whitish areas of undigested fascia and exhude an abundant red or yellow serum. This drainage causes the systemic protein deficiency and anemia, if allowed to continue. Repeated infections and loculations cause purulence and fever, malaise and poor appetite, and a vicious cycle is begun which is very difficult to reverse.

The organisms present in pressure ulcer are the usual pathogens found in skin wounds: staphylococcus, streptococcus, escherichia coli, bacillus proteus, pseudomonas aeruginosa. Antibiotics given systemically are of questionable value because of an abundant scar tissue barrier and vessel thrombosis which prevent the antibiotics from getting to the site of infection. In septic situations where recurrent and elevated temperatures are present, indicating bacteremia, therapeutic doses of specific antibiotics are definitely indicated. The genito-urinary tract is a frequent site for infection and should be investigated periodically as this may

Figure 5

Diagram on patient of the plan for excision of an ischial pressure ulcer and an inferomedially based 2:1 flap.

cause temperature elevation even with a clean wound.

Sites

Some variable factors exist with regard to sites of pressure ulcers. Spastic paraplegics develop knee, elbow, or malleolar ulcers readily because of movement and brush burns on sheets from muscle spasm. A bed-bound patient develops heel and sacral ulcers. Prone patients develop more costal and iliac spine ulcers. Wheel chair and sitting patients develop more ischial and pressure ulcers from braces. Also the position of a patient in a room with regard to roommates and a TV set is an example of why a patient will develop a right or left sided lesion. A chart of sites by various investigation is seen in Figure 9.

Treatment

We will consider only the treatment as it pertains to the patient and his pressure ulcer. The treatment of pressure ulcer is divided into two categories, systemic and local.

Under systemic treatment, a consideration of the nutritional measures are paramount. A high protein, high calorie, high vitamin diet is important in restoring and maintaining normal nitrogen balance since most of these patients are already in negative nitrogen balance. Low fat and low carbohydrate intake help in preventing the storing of fats in the body. Stimulating the appetite in an inactive patient can be a problem and can be accomplished by methods such as wine before meals, insulin, or anabolic steroids. The therapeutic vitamin intake also stimulates a good diet and restores the vitamin pool to normal balance in the body.

The serum protein level should be 6 gm/100 cc or above before surgery is performed. Psychologic stimulation or a desire on the part of the patient to get in better condition and get the surgery over is a good sign and insures the patient's cooperation. A good nursing and paramedical personnel is important in accomplishing this aim. The physician in charge of the patient must keep him interested and stimulated. He gives the patient goals and time limits. By keeping them, he eventually gains the patient's confidence no matter how depressed or hostile he may have been on admission.

Treatment of anemia, if present, is usually concurrent with correction of vitamin and protein deficiency. These people have either nutritional or blood-loss type anemia. If time is available, the preferable method of treatment is by nutritious diet and therapeutic vitamin replacement. Whole blood or packed red cell transfusions can also be given judiciously, but the hemoglobin should be 12 grams (80 percent) or above before surgery.

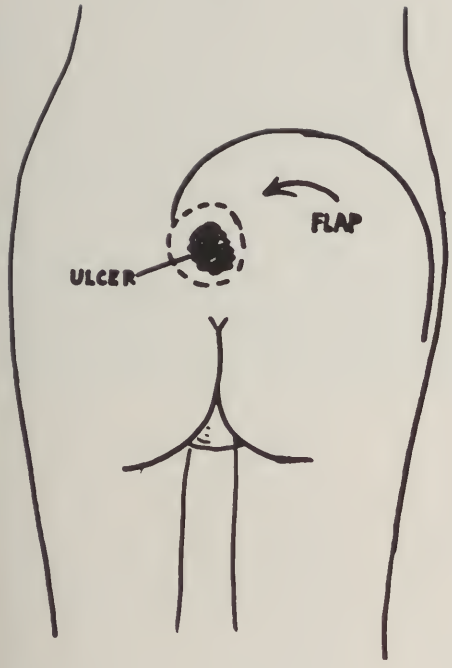
Spasm is a problem in almost one-half of paraplegics and a higher percentage of quadraplegics. This may interfere with surgery. A consultation between the physiatrist and the neurosurgeon as to how this is best managed is warranted. It must be a judgment which best fits each individual patient. Alcohol injection, rhizotomy, or both have been tried in the past. These procedures may abolish some autonomic and reflex activity of bladder and sexual apparatus and may be more debilitating in a psychologic sense to these patients than the little good they may accomplish. Harding, who studied and reported on the rehabilitation of 100 paraplegics in Pennsylvania in 1961, felt that these measures were only of temporary help in one-half the cases and should be abandoned. Procaine block can be used, but more sophisticated selective neurosurgical procedures are now available.

The relief of pressure is of prime interest in the ulcer area. The patient should be placed on a turning schedule which protects the ulcer as well as other pressure points. The patient should be specifically watched for pressure areas and adequate use of pillows and foam rubber or urethane plastic in large blocks, cut to fit the patient, can be used. This is the responsibility of the physiatrist and the rehabil

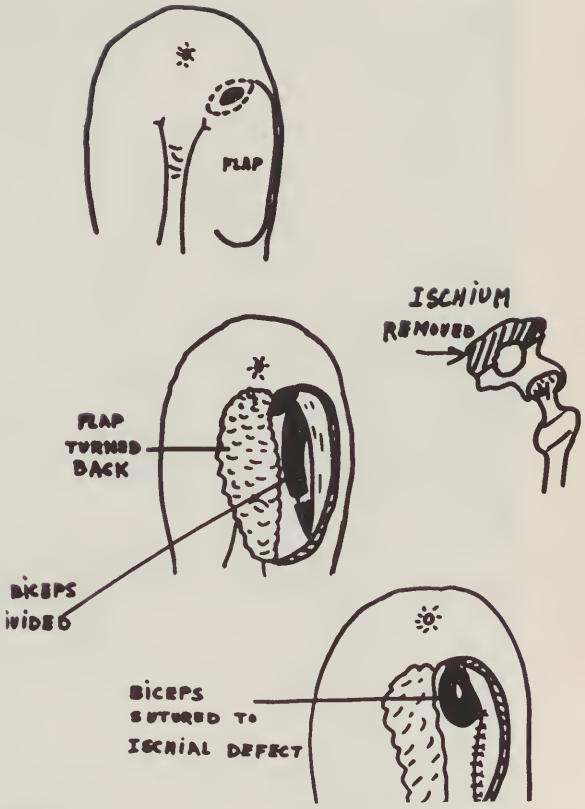
Figure 6

Diagram of the plan for excision of a sacral pressure ulcer.

Figure 7



A.



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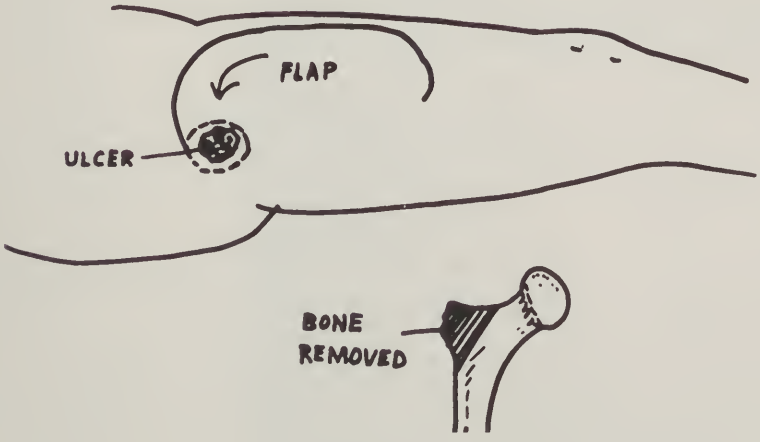


C.

A. Diagram of excision and design of flap used to close sacral ulcer.
B. Ischial pressure ulcer.
C. Trochanteric ulceration.

Figure 8

A: Large sacral ulcer with bone exposure.
B: Surgery complete: flap rotation and primary closure.
C: Complete healing: six months postoperative photograph.

itation staff of nurses. I would like to state emphatically my personal opinion that the patients do better in a rehabilitation unit with nursing and ancillary personnel, who are better attuned to the specific needs and requirements of this type of patient, be he paraplegic or quadraplegic. A sense of team effort also helps. Trained personnel know better what is expected of each type of patient than general duty nurses in a general hospital setting.

Mattresses designed for reducing pressure are used if needed. The canvas seats and slings of wheel chairs are removed and replaced with plywood and foam blocks which have areas cut out of them to protect the pressure area. Alternating pressure air mattresses are also available and can be ordered if the patient has a tendency to break down in other areas when one ulcer is under intensive treatment. A water bed is advocated in patients with multiple areas of breakdown or threatened breakdown, especially if he is in poor nutritional state. This distributes pressure over the entire body evenly. A disadvantage of the water bed is that body heat dissipation is poor because it is made of rubber or plastic. The Stryker or Foster Frame or circlectric bed is ideal for managing this severe type problem. Patients take some time to adjust to this bed, but it is better to control turning, and it gives a good padding to pressure areas. A greater variety of positions is available with this bed.

The newest device in relieving pressuring is the air bed, which has pellets of silicone much like a sand bed. A pump projects multiple jets of compressed air under this bed of silicone particles on which the patient lies. The patient floats on a bed of air and plastic pellets. The ulcer is left open and is placed directly in the bed. The air has a drying effect as well producing a massaging effect on the ulcer and pressure free surface. The motor is noisy, but patients eventually become accustomed to it and it is said to have an overall relaxing effect. These beds are now on the market and are useful adjuncts in the treatment of this problem. The individual cost is very high, however.

The local treatment of ulcer is actually nothing more than the application of basic surgical principles to the s

Figure 9

SITES AND INCIDENCES

	240 S Yeoman & Hardy	1,604 s 649 pts. Conway et al
Ischium	28	28
Sacrum	27	17
Heel	18	9
Trochanteric	12	19
Ext. maleoli	8	5
Tibial crest	4	5
A. S. spine	2	2.5
Scap.	-	4
Costal Margin	1	0
Elbow	0	1

ific needs of the patient. Begin with horough cleansing with a good antiseptic (pHisoHex® Winthrop) two or hree times daily. If debris is present or he ulcer is undermined widely, ydrogen peroxide is our choice to ollow because its foaming action emoves or loosens debris. It also lelivers oxygen to the areas of the lcer which are at a low oxygen tenion to begin with. Some authors refer zinc peroxide paste.

If debris is present and fascial material or necrotic tissue, such as ynovium or muscle, is still adherent in he depths of the wound, sharp surgical debridement should be carried out. Enzymatic debridement is probably too slow for this situation. After the ulcer is washed with pHisoHex, rinsed with hydrogen peroxide, and surgically debrided. I prefer to loosely pack the wound with one inch iodoform gauze. This chemotherapeutic agent does two things; it is a strong antibacterial agent, and it will sterilize a wound in a short time. It also is a powerful chemical irritant to the tissues which decreases the thickness of the granulation tissue. Because of its irritating quality to tissues, it stimulates a tendency to close the undermined area, thus encouraging scar formation. Incidentally, it also deodorizes the wound. This regimen is desirable for at least a week prior to surgery while the patient is being prepared for surgery from a systemic standpoint.

Figure 10

CLINICAL STAGING

Stage 1 - Simple skin erythema.
Stage 2 - Redness, swelling, induration with occasional blistering.
Stage 3 - Skin destruction with fat exposure.
Stage 4 - Necrosis of skin and fat extending to fascis and muscle.
Stage 5 - Skin fat and muscle necrosis.
Stage 6 - The above with bone involvement.
Stage 7 - All the above with osteomyelitis, septic arthritis, pathologic fracture, gross dislocation and septicemia and death.

Most clinicians define an acute or chronic stage of pressure ulcer but for a better understanding and precise definition, Campbell classified seven distinct stages of pressure ulcer.

Another recent method of local treatment of the pressure ulcer which was reported in *Lancet* in 1969 by Fischer is the application of Hyperbaric oxygen, applied to the ulcers by two methods. One is a rubber chamber similar to a pair of pants into which the oxygen is pumped under pressure. Another apparatus is the plexiglas cup which is applied to the local ulcer and is best adapted to the sacral area where piston pressure regulator is present. It was found to hasten vascularization, supress bacterial growth, and stimulate capillary growth. It is used for eight consecutive hours per day and applied approximately three weeks or longer. It is a newer adjunct and is expensive, requiring specialized equipment.

Surgical Treatment

After all of the aforementioned conditions are satisfied and the patient is in the best of nutritional condition, when he is psychologically oriented to the surgical treatment and rehabilitation, and when whole blood is on hand, only then should surgery be carried out. Most patients who have paraplegia or quadraplegia have anesthesia over the operative area. Surgery can then be performed under a heavy premedication or intravenous tranquilizer such as Valium. The intravenous drip should be running and an anesthestist should be in attendance during surgery. The principles of surgery on pressure ulcer listed by Herrold Griffith are followed in our treatment of this problem. They are:

1. The ulcer is excised along with the surrounding scar and underlying bursa, as in trochanteric and ischial ulcers.
2. The underlying bony prominence is thoroughly resected (i.e., the entire trochanter, the ischial tuberosity). Some resect the entire ischium. We do not feel this is necessary or even advisable as it may be the cause of urethral fistulas.
3. Any soft tissue calcification is removed from the area.
4. Careful hemostasis should be carried out. Suture ligation of all

bleeders is carried out. The Bovie is not used as this may tend to produce more serum accumulation under the flap because of the electrical stimulation and irritation of tissue.

5. Continuous postoperative wound suction is used as long as is necessary, or until less than 5 cc. of drainage per 24 hours is seen. If necessary, some hemovacs have been in place for two weeks.

6. Fascial or muscular covering of the bone is used for padding and for obliterating dead space.

7. A large rotation flap of skin and fat is used to close the wound. A 1:1 length to width ratio is ideal. The donor site can usually be closed by advancing tissue. Occasionally a skin graft is needed, however.

8. Careful wound closure is paramount. A heavy chromic catgut suture of No. 0 or No. 1 chromic catgut in large circles in the fatty layer is placed in an interrupted inverted fashion. This layer closes the wound, making it air tight and watertight. All the tension of the flap is placed on this layer. The skin is closed with 3-0 monofilament nylon, and the sutures are removed in two to three weeks. Postoperatively, a compression dressing of padded gauze, using tincture of Benzoin and elastoplast, is used. This seals the wound from soilage from the anus. This is changed usually in five to seven days if no problems are encountered such as fever, drainage, or occlusion of the Hemovac tubing.

The patient is placed on the Stryker frame postoperatively. I feel that patients are much better managed and controlled here. Psychologically it restricts the patient somewhat in the important postoperative period. Antibiotics are used postoperatively for ten days. Sodium Nafcillin is the choice because of its fairly broad spectrum. Since the operative site is contaminated initially, we believe that the use of prophylactic measures, in this modern day when excellent drugs are available, should be used as an adjunct in the whole treatment of the patient. If an infection should become established under a wide, newly-elevated flap of tissue, the surface area of infection is doubled or trippled and the serious complications and delay in eventual rehabilitation of the patient would ensue and would be hazardous.

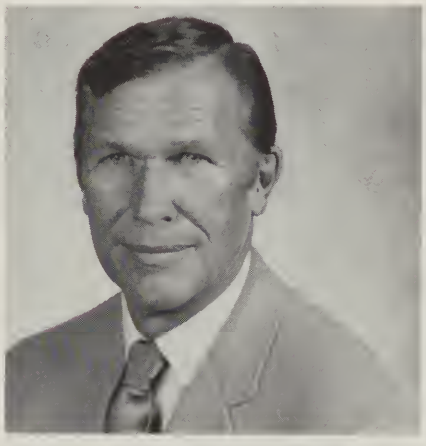
Specific Flap Design

Sacral ulcers require a large flap which is designed over one buttock and is based infero-laterally (Figure 7A). Ocasionally, because of extreme size of the ulcer, bilateral buttock flaps are necessary. Occasionally the upper back must be used if ischial ulcers are present and may be required for flaps in that area at a later time. A bipedicle lumbar flap may be indicated at other times and may require one or two-stage delay. Split thickness grafts may be necessary to cover the donor site, depending on the flaccidity of the tissues surrounding the flap bed. Usually closure can be accomplished by advancing loose surrounding tissue in the conventional sacral flap.

Trochanteric ulcers require a large rotation flap of 1:2 length to width ratio for adequate closure (Figure 7-C). It is preferable to base this posterio-laterally. Sliding bipedicle flaps may be used in smaller ulcers. Stellate closure over a trochanteric area is usually not effective, as it places considerable scar over a pressure point and may break down later.

Ischial ulcers are best closed by a large posterior thigh flap after ischial tuberectomy and the biceps muscle flap used to fill in the defect. A linear closure is suited only for very small ulcers in people with considerable redundant tissue in the ischial region. A length to width ratio of 1:2 or 1:3 is needed for the convential flap in this area (Figure 7-B). Generally a medial based flap is best rotated to close the defect in the ischial area.

Other ulcers in the body require ingenuity and experience in planning and execution of flaps that best accomplish coverage and protection. The heel and malleolar areas are the least successful as far as closure by local flap because of poor vascularity and inflexible tissue and considerable fibrous base over tendons and fascia.



Dr. Herceg, left, is senior associate plastic surgeon at Harrisburg Hospital, Harrisburg Polyclinic Hospital, and Holy Spirit Hospital, Camp Hill, and is clinical assistant professor of surgery at Pennsylvania State University College of Medicine, Hershey. He is consultant in plastic surgery at the State Hospital for Crippled Children, Elizabethtown. This paper was presented at the Third Annual Orthopedic Meeting at the latter institution. Dr. Harding, a former plastic surgeon at Walter Reed Army Hospital, is presently chief of plastic surgery at Harrisburg Hospital, chief of plastic and maxillofacial surgery at Harrisburg Polyclinic Hospital, and associate clinical professor of plastic surgery at Pennsylvania State University School of Medicine, Milton S. Hershey Medical Center.

Summary

The etiology of pressure ulcers are discussed. Conservative method of treatment and preparation of the patient and the wound is enumerated. The details of surgical treatment with illustrations are outlined. □

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Clinical Applications and Value of Coronary Arteriography in the Cardiac Patient

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Table 1. Indications for Coronary Arteriography

I. Diagnosis
- A. Chest pain of unexplained origin.
- B. Unexplained ECG abnormality.
- C. Evaluation of the etiology of obscure arrhythmias.
- D. Undiagnosed heart disease.
- E. Recognition of coronary atherosclerosis associated with other heart disease.

II. Therapy
- A. Severe angina pectoris or coronary disease in patients considered for coronary artery surgery.
- B. Medical therapy.

CORONARY arteriography has become a technique of considerable usefulness in clinical practice, having evolved from an occasional, experimental tool to an established, frequently performed diagnostic method. The procedure affords a highly accurate means of evaluating the anatomy of both normal and diseased coronary vessels providing that the arteriograms are of high quality and are interpreted by experienced personnel.[1]

The use of this technique has contributed importantly to our understanding of coronary heart disease and, in the light of recent advances,[2-7] it is timely to review the utility of coronary arteriography to the clinician. In several clinical situations, the information that derives from coronary arteriography significantly enhances the ability to diagnose and manage the cardiac patient.

Indications for Coronary Arteriography

Diagnosis:
Chest pain of unexplained origin.

Patients with chest pain in whom the etiology is uncertain often present a difficult diagnostic problem. The anxiety, despondency, and fear of death that so often occurs in these patients can make them emotional invalids. This is often eliminated by demonstrating a normal coronary arterial tree angiographically. The physical disability and psychological risks of cardiac neurosis are only two of the factors to be considered in this group of patients. Thus the decision to perform arteriography must be made on an individual basis.

Unexplained ECG Abnormality

Nonspecific changes in the electrocardiogram have often lead to the erroneous diagnosis of coronary disease. This is especially true of nondiagnostic abnormalities of the ST segment and the T wave. These ECG diagnoses are often utilized as the basis for job restrictions or life insurance disqualification. In addition, a positive Master's two-step exercise test has not infrequently been observed in patients with a normal coronary arteriogram.[8]

Thus, it is often of value to establish a definitive diagnosis in these patients.

Evaluation of the Etiology of Obscure Arrhythmias

Recent studies have demonstrated that approximately 70 percent of the mortality from arteriosclerotic heart disease occurs in patients who die so suddenly that they never reach the hospital.[9] In particular, the incidence of sudden death is six[10] to tenfold[11] greater among persons with ventricular premature beats than those without ectopic beats. The determination of the underlying etiology of this and other arrhythmias commonly associated with coronary artery disease such as "lone" atrial fibrillation and bundle branch block is critical since it is now known that these arrhythmias may be found in patients with normal coronary arteries.

The precise etiology of the arrhythmia relative to coronary artery disease more clearly identifies the potential victim of sudden death and will guide the degree of therapeutic vigor of a prophylactic, antiarrhythmic drug program. This is especially important in view of the significant incidence of side effects associated with antiarrhythmic drugs.[12]

It should also be mentioned that in patients with bundle-branch block or other forms of heart-block newer electrode catheter techniques are also at hand for localizing the site of the block which can be ascertained during the same catheterization procedure.[13,14] This additional information has importance in considering indications for pacemaker insertion.[14]

Undiagnosed Heart Disease

In the evaluation of the etiology of cardiomegaly and/or congestive heart failure of obscure origin, coronary arteriography is a valuable adjunct in defining the possible role of coronary atherosclerosis. Many patients in this category carrying the label of coronary heart disease are found to have a myocardiopathy with normal coronary arteries. The prognosis in the two cases is markedly different.

Recognition of Coronary Atherosclerosis Associated With Other Heart Diseases

This is especially useful in managing the patient with hypertension or aortic valve disease. In the patient with aortic stenosis and angina pectoris, it is critical to define the relative contributions of the valvular stenosis and coronary artery lesions since these two abnormalities frequently co-exist. Clearly the management of the patient with severe aortic stenosis and minimal coronary disease will differ markedly from the patient with minimal aortic stenosis whose anginal symptoms are caused primarily by severe coronary artery disease.

Therapy

Severe Angina Pectoris or Coronary Disease in Patients Considered for Coronary Artery Surgery

The development of selective coronary arteriography has stimulated progress in the application of surgical techniques directed toward improving blood flow to the myocardium. Surgical revascularization by internal mammary artery implantation[15] and more recently by saphenous vein bypass of a severely stenotic coronary lesion[16] have become increasingly utilized forms of therapy. It is essential for any patient being considered for coronary artery surgery to be studied arteriographically to anatomically define the site and severity of the stenotic lesions. Without this anatomic definition, the type of surgery and the site of surgical intervention cannot be rationally planned.

Medical Therapy

A vigorous therapeutic program, including coronary vasodilators, beta adrenergic blockade, antithrombotic agents, lipid-lowering therapy, antiarrhythmic therapy and supervised physical exercise programs can be more rationally planned when the site and anatomic extent of coronary disease as well as its effects on the myocardium are precisely demarcated. This is especially true of young adults with angina pectoris in whom a vigorous program of therapy is desirable.

Table 2
Adjuncts to Coronary Arteriography

A. Stress testing
   1. Muscular exercise
   2. Right atrial pacing

B. Left ventriculography
   1. Vigor and uniformity of contraction
   2. Asynergy and asymmetry
   3. Aneurysm formation

C. Hemodynamics
   1. Intracardiac pressures
   2. Cardiac output

Contraindications

The major contraindication to coronary arteriography is the presence or recent occurrence of an acute myocardial infarction. In addition, patients with acutely increasing or suddenly changed pattern of angina should not be studied until the clinical situation has been stabilized.

Errors in Interpretation

Experience in interpretation and arteriographic studies of high quality are both essential to prevent incorrect diagnosis. Two-dimensional studies must be performed and extrapolated to three-dimensions. Failure to observe this principle can cause a significant lesion to escape recognition in a vessel that is "end-on" in a single projection. This requires precise knowledge of coronary arteriographic anatomy.

The degree of coronary artery narrowing is an important gauge of its significance. The differentiation of significant stenosis from benign spasm, "layering" of contrast material, or "myocardial bridges" can be made by assessment of the velocity of flow past the lesion during all phases of the cardiac cycle, the presence of collaterals and the response of the lesions in question to coronary vasodilators.

Adjuncts to Coronary Arteriography

It should be emphasized that although the arteriogram accurately displays the anatomy of the coronary arteries, it tells little about the physiologic effects of the coronary arterial stenosis. In particular it is important to assess the impact of a coronary stenosis relative to production of myocardial ischemia and ab-

rmalities of left ventricular contraction and function.

The technique of right atrial pacing s been developed[17] and utilized to idy the hemodynamic and metolic[5,18] effects of coronary artery sease. Atrial pacing has proved a safe ethod of stressing the myocardium id of producing a controlled ischemic ate, with several advantages over exercise stress.[18] This technique has also en utilized to unmask unequivocal idence of myocardial ischemia in pants with typical angina pectoris and normal coronary arteriogram.[19]

An invaluable adjunct to coronary teriography is left ventriculography, hich displays the effect of the oronary artery disease on the pattern f contraction of the left ventricle.[20] bnormalities in the symmetricity of entricular contractions and aneurysm ormation are the most important auses of congestive heart failure in atients with coronary heart disease.[20] Often, these contraction abnormalities an be unmasked by propranolol administration.[21]

The effects of the disease process on emodynamics (i.e. intracardiac pressures and cardiac output) are important guides to therapy.[21]

Preliminary evidence has begun to ccumulate that the data derived from coronary arteriography has prognostic ignificance.[22] In addition, the arteriographic demonstration of a coronary collateral circulation has been found to have important implications to the patient with coronary artery disease.[23]

Complications of Coronary Arteriography

Many of the risks of coronary arteriography are similar to those of percutaneous thoracic aortography, namely arterial complications and allergic reactions. Data from several centers recently compiled in 3,312 patients indicated an overall complication rate of 1.9 percent.[24] Arrhythmias were the most common complications having occurred in 0.82 percent of the studies.[24] Five patients sustained myocardial infarction during or immediately after coronary arteriography; death occurred in two of them.[24] Experienced personnel, careful monitoring of cardiac rhythm, adequate facilities for immediate resuscitation and cardioversion and prompt surgical intervention in the event of vascular complications are mandatory. Under these circumstances complications should be minimal.

Conclusions

The technique of selective coronary arteriography has proved of great importance in better understanding the patient with coronary heart disease. Before the development of this technique, the diagnosis of coronary heart disease rested solely on indirect evidence. The combination of coronary arteriography with stress tests to unmask objective evidence of ischemia, as well as ventriculography and hemodynamics to determine the effects of the coronary disease process on the myocardium, enables an accurate diagnosis to be made of the presence, severity, and extent of coronary artery disease in living man. In experienced hands, this technique is of considerable help to the clinician enabling accurate diagnosis, more rational therapeutic planning, and a better prognostic guide in the management of the cardiac patient. □

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Myoglobinuria and Renal Failure with Myopathy

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Acute alcoholic myopathy may present as an overwhelming syndrome of muscle pain and tenderness associated with myoglobinuria and acute renal failure. Other patients may show only marked elevations of serum levels of muscle enzymes including glutamic oxaloacetic transaminase (GOT), aldolase, and creatine phosphokinase (CPK). Intermediate stages of these two syndromes of acute alcoholic myopathy may present with varying degrees of muscle pain, tenderness, and cramps. The case listed below presented with a number of associated unique features.

Report of Case

A forty year old negro woman with a chronic alcoholic history was admitted to Philadelphia General Hospital after heavy alcoholic ingestion. Two days before admission she became unable to move, began to vomit, and cough a whitish sputum. She had also been oliguric for two days, producing scant brownish urine.

The patient had received treatment

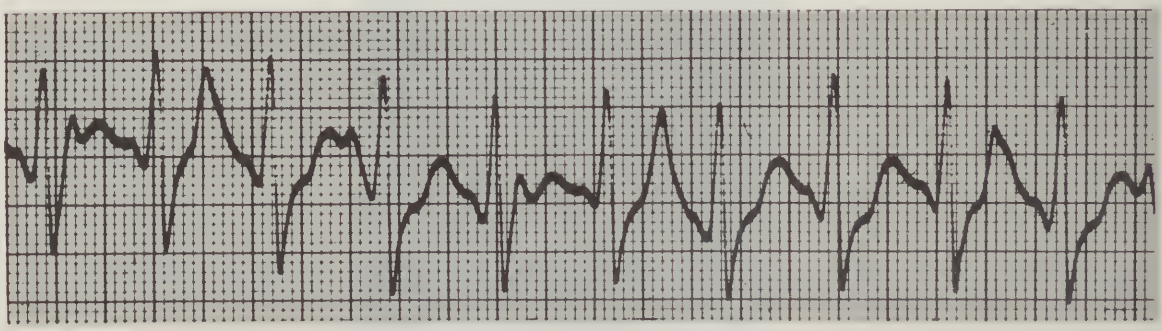

Figure 1: Illustrates a rapid ventricular tachycardia.

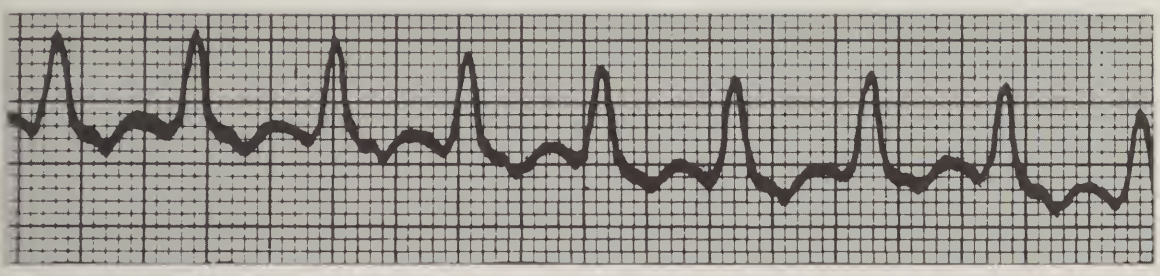

Figure 2: Illustrates a low nodal rhythm.

or a kidney infection several weeks earlier and had developed peripheral edema.

There was no prior history of renal disease, diabetes mellitus, hypertension, rheumatic fever, scarlet fever, or convulsive disorder. She had no prior cardiac disease or muscle disorder.

Physical examination revealed a dyspneic pale Negro female. Blood pressure was 60/30. Pulse was 160 and slightly irregular. She displayed diffuse rales and rhonchi bilaterally. No nuchal rigidity was noted. Heart sounds were not audible. The abdomen was silent. Neurologic examination revealed marked motor weakness of all extremeties; no fasciculations were noted; sensation was intact as was proprioception. Cranial nerves were normal. Reflexes were somewhat decreased by equal bilaterally. No abnormal reflexes were noted. Coordination was impaired secondary to marked muscle weakness.

Electrocardiogram showed ventricular tachycardia (see Figure 1). The CVP determination registered 22 cm. of pressure. At this time 250 mg. of procaine amide was given in a single bolus and the rhythm reverted to a low nodal rhythm. (see Figure 2). A second bolus produced an idioventricular rhythm with a rate of twenty per minute. 1 cc. of 1/1000 epinephrine produced a tachycardia (rate 110). The T-waves on the electrocardiogram appeared tall and the serum potassium on admission was 8.5. With resumption of low nodal rhythm, the rales disappeared and the CVP measured 6-7 cm. of pressure.

The administration of 50 mgm. of ethacrynic acid I.V. produced only 100 cc. of urine in an hour; a second dose of 100 mgm., plus 30 cc. of mannitol (12.5 gm.) resulted in 10 cc. in another hour of urine flow.

At this time, with a total intake of 3500 cc. of fluid and virtually no output, peritoneal dialysis was begun. Dialysis, proceeded satisfactorily, but the patient remained oliguric with only 60-70 cc. of urine per day.

Laboratory data on admission showed a sodium of 132, potassium of 8.1, CO_2 of 12.5, chloride of 96, BUN of 110, hemoglobin of 13.7, WBC 16,500, SGOT 4000, and LDH of 4688. Urinalysis was essentially normal except for WBC's. An initial urine myoglobin test was negative but repeat study was positive. Serum haptoglobin measured 200 mgm%. An initial CPK was drawn just prior to dialysis and measured 1875 (normal 0-30).

Following dialysis, the patient remained oliguric with only 60 cc. output per day.

The high potassium fell to 4.7 within eight hours and the BUN was reduced following dialysis. The SGOT and LDH remained very high.

Dr. Coodley is chief of medicine, Hahnemann Division, at Philadelphia General Hospital and a professor of medicine at Hahnemann Medical College and Hospital. Dr. Lee is on medical service, Hahnemann Medical Division, at Philadelphia General Hospital.

The patient continued to show marked generalized muscle weakness despite therapy. No localizing signs developed and the remainder of the neurologic examination was unchanged. A Tensilon test was negative. A muscle biopsy (Figure 3) showed diffuse and extensive damage. There was considerable variability in size of fibers, some undergoing degeneration whereas others were in the process of regeneration. The latter fibers were surrounded by numerous sarcolemmal cells with large nucleoli. There was a scanty mononuclear and histiocytic infiltration both within and around the vessels.

A renal arteriogram and an intravenous pyelogram, performed at the end of the first week, were entirely normal. There was no finding of ovoid venous casts of the renal pyramids, as would be expected with renal vein thrombosis. Both renal shadows were markedly and symmetrically enlarged.

Dialysis was repeated three times after the initial dialysis to control the increasing BUN and hyperkalemia; however, in approximately two weeks, the patient began excreting increasing volumes of urine and the elevated BUN fell to 55 mgm%.

During the entire period of hospitalization, the patient maintained a low grade fever and produced tenacious respiratory secretions, finally requiring tracheostomy and frequent lavage and aspiration.

Repeat enzyme studies showed

Figure 3: Longitudinal section of muscle showing degeneration of individual fibers and striking proliferation of sarcolemmal nuclei.

marked elevation of SGOT and SGPT with levels over 1000 and CPK of 775 units. The muscle weakness became so severe that the patient was unable to move her arms or legs more than a few inches at any time during her hospital stay. The weakness involved primarily the proximal muscle groups. Electromyography revealed evidence of primary myopathy. Neurologic examination remained unchanged.

The patient sustained a cardiac arrest after three weeks of hospitalization and resuscitation efforts were unsuccessful.

Comment

This case illustrated a number of unique features, i.e., profound and continued muscle weakness following alcoholic excess, marked elevation of serum muscle enzymes, development of ventricular tachycardia in association with the liberation of large amounts of potassium from injured muscle tissue, development of reversible renal shutdown from myoglobinuria, and development of progressive widespread weakness without associated neurologic change.

Myerson reported elevated CPK levels in twenty-one of twenty-four patients with delirium tremens (DT's) and in fifteen of twenty patients with acute alcoholism without myopathy or delirium tremens. He postulated that alcohol had a direct toxic effect on muscle cell with alteration of membrane permeability allowing release of intracellular enzymes into the serum.

In a detailed review of the diagnosis and treatment of muscle diseases, Dowben indicated that myoglobinurias were usually associated with crushing injury, acute ischemia of muscle due to vascular disease, following prolonged and severe muscular exertion, or following ingestion of toxins. Paroxysmal myoglobinuria usually occurs in adolescence, and more often in males. Myoglobinuria includes the acute onset of muscle tenderness and pain, followed by wide-spread weakness and excretion of myoglobin in the urine, giving it a red to brown hue.

Klinkerfuss described myoglobinuria, with muscle tenderness, fever, increased levels of muscle enzymes, and often acute renal failure, as occurring following acute alcoholic episodes. He indicated that alcoholics may have minimal muscle symptoms but still manifest elevated CPK levels and a decreased ability to raise lactic acid with ischemic exercise. Perkoff suggested that the diagnosis of alcoholic myopathy may include a history of acute alcoholism, muscle symptoms, elevation of the CPK enzyme level, and frequently the presence of myoglobin in the urine.

Diagnostic modalities in muscle disease include clinical history, with mode of progression in distribution of muscle weakness, electromyography, nerve conduction measurements, serum enzyme levels, and muscle biopsy. Marked elevation of CPK with reference to muscle diseases is limited to muscular dystrophy and acute myositis.

The myoglobinuric myopathies may be classified into the following groups: (a) idiopathic, (b) stress-induced, (c) secondary to polymyositis, (d) with McArdle's Disease, (e) with alcoholism, (f) with trauma, and (g) with vascular insufficiency. The following enzymes are frequently elevated in muscle disease: GOT, GPT, LDH, aldolase and CPK. The CPK determination is felt to be the most reliable and sensitive indicator of muscle fiber breakdown. Minimal rises in CPK are found in thyroid myopathy, periodic paralysis, and physical exercise. Marked elevations are noted in muscle dystrophy and polymyositis.

When one considers the large potassium store released by the potassium rich muscles, fulminant myocardial potassium intoxication is a likely cause of sudden death. This patient developed a rapid ventricular tachycardia and later a nodal rhythm secondary to acute severe hyperkalemia.

Increased concentrations of serum potassium result in peaking of the T-wave, widening and disappearance of the P-wave, prolongation of the P-R interval, prolongation of the Q.R.S. complex, and appearance of prominent S-waves. At levels above 5.5 mEq./L, these changes are more constantly present and there is, in addition, depression of the S-T segment. Arrhythmias may be associated with severe abnormalities in electrolyte levels and the nodal rhythm noted in this patient was probably related to hyperkalemia.

One of the unusual features about this patient was the very severe and generalized muscle weakness. This persisted and progressed throughout the hospital stay and the patient was virtually unable to lift the extremities. The biopsy study reflected the very severe, diffuse damage in the muscle fibers. No neurologic evidence of any syndrome was found to account for the muscle weakness other than the alcoholic myopathy.

The markedly increased enzyme levels served as an accurate index to the severity of the myositis and persisted throughout the hospital stay. □

Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Many patients on special diets will find soups they can enjoy among the more than 50 different varieties available.

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A triumph over trichomoniasis

The male urogenital tract is by far the main source of reinfection in trichomonal vaginitis.

It follows that neglecting to treat infected male partners of women with trichomonal vaginitis invites therapeutic failure.

Just as Flagyl is the best agent available for eradicating trichomonal infection from extravaginal sites in women, it is the only agent capable of eradicating demonstrated trichomonal infection in men.

Because of published reports of consistently high cure rates—often up to 100 percent—and a relatively low incidence of side effects, Flagyl has become the agent of choice for trichomonal vaginitis.

Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, active organic disease of the central nervous system and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia*, exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets 250 mg.
Vaginal inserts 500 mg.

References available on request.

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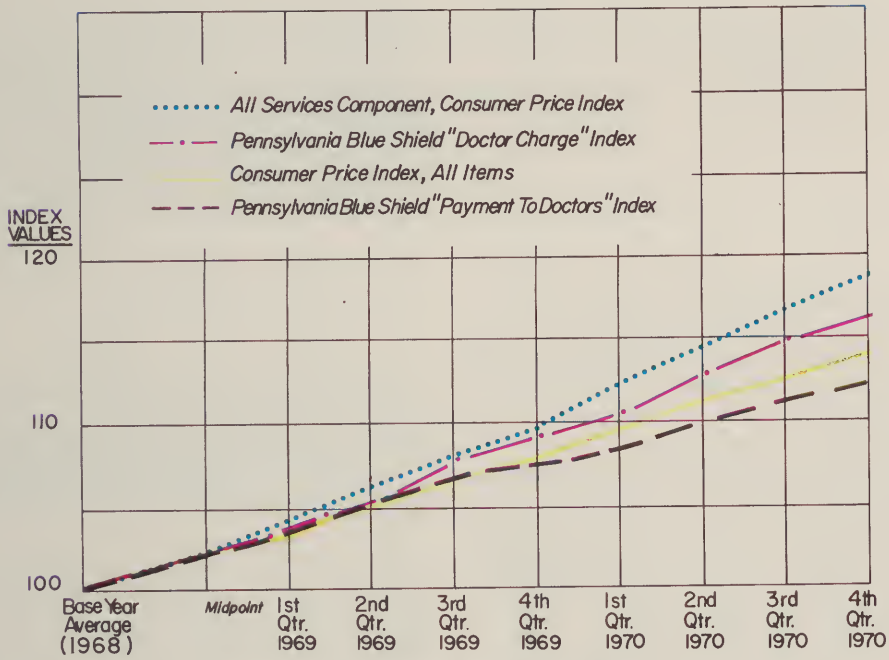
The charge-payment index system, Its data base and how it works

GENE A. MARKEL, RESEARCH DIRECTOR

Pennsylvania Blue Shield

TABLE I

Pennsylvania trends in physician charges and Blue Shield payments compared to consumer price index trends



BY THE END of 1970, the Pennsylvania Blue Shield (PBS) Index of Physician Charges had risen 16.2% and the PBS Index of Payments to Physicians had risen 12.0% in relation to average charges and payments recorded during the base year of 1968. During the same time period, beginning from the midpoint of the base year 1968, the Consumer Price Index (CPI) went up 13.8% and the All Services Component of the CPI went up 18.7%.

THE CONCERN over rising costs of health care is nationwide and growing ever more intense.

Realizing a definite and immediate need to find out how his problem is more specifically affecting the health industry in the Commonwealth, Pennsylvania Blue Shield addressed itself to at least one aspect of the concern and discovered that the physician charge image in the Keystone State is far more attractive than the Consumer Price Index (CPI) reveals for the entire country.

Pennsylvania Blue Shield has developed a Charge/Payment Index System designed to monitor trends in charges made by Pennsylvania physicians and in payments made to these physicians by Blue Shield.

Results obtained from a recently completed two-year study (Table I) using the index system indicate that Pennsylvania physicians' charges increased at an average annual rate of 6.8% during the two-year period covering 1969 and 1970. During this same period of time, the all services component of the CPI reported an average annual increase of 7.9% nationally. The Pennsylvania Blue Shield index for

payments to physicians rose at an average rate of 5.1% annually during this same two-year period. During the 1969-1970 period, the CPI for all items went up at an average annual rate of 5.8%.

These figures show that there is an upward trend in the cost of physicians services in Pennsylvania, but that charges of physicians in the Commonwealth are not going up as steeply as the costs of services in general.

Observing that the Pennsylvania Blue Shield Payment Index shows the least increase of all, it may be noted that this is consistent with Blue Shield's responsibility to exercise cost controls and generally to exert a restraining influence on the costs of medical care and services.

The study also shows that certain individual categories of service behave in a manner distinctly different from the overall patterns indicated by the general charge index. In this connection, it may be noted that obstetrical delivery, anesthesia, and in-hospital medical care categories have shown the fastest rise in both charges and payments. Surgery, consultation, and diagnostic x-ray services showed increases that were slightly less than the average, while diagnostic medical and pathology services showed the smallest increases in average charges and payments during the two-year period covering 1969-1970.

How The Index System Works

The Charge/Payment Index System is based upon an analysis of the charge and payment patterns evident in a selected sample of 133 commonly performed procedures. The spectrum of physician services encompassed by these 133 procedures includes surgery, dental surgery, obstetrics, anesthesiology, in-hospital medical care, diagnostic x-ray, pathology, and consultation.

The procedures selected for inclusion in the sample cover well over half of the total number of physician services performed under Prevailing Fee coverage during the study period. They also cover well over half of the total dollars paid to Pennsylvania physicians by Blue Shield under the Prevailing Fee Program during that period.

For each individual procedure in the sample, data on charges, payments, and numbers of services provided are accumulated by retrieving information from the records of actual claims approved for payment.

For each of the 133 procedures, the current average charge is calculated by dividing the number of services of a given procedure into the total dollar value accumulated for those services. If there were 328 appendectomies performed under Prevailing Fee during the most recently completed quarter, and the total amount paid out by Pennsylvania Blue Shield for these 328 services was $55,796, for example, then it is a matter of simple arithmetic to compute the current average charge for appendectomy as being:

$$\$55{,}796 \div 382 = \$170.11$$

Current charge index values for each procedure then can be determined by reference to a previously calculated set of average charge values for these same procedures over some fixed earlier span of time selected to serve as a ba (or reference) period. More specifically, the char index value for a single procedure is determined by dividi the current average charge by the corresponding avera charge for the base period and multiplying the answer b 100. For example, if the average charge for a tonsillecto now is $80, but had been $75 during the earlier period time selected as the basc period, the charge index for to sillectomy would be calculated as:

$$\text{(step 1) } \$80 \div \$75 = 1.067;$$
$$\text{(step 2) } 1.067 \times 100 = 106.7$$

The first step expresses the ratio of the current averag charge to the base period average charge in decimal form The second step simply accomplishes a change of scale tha facilitates interpretation of the result. In particular, it ma be noted that the result from the second step is analgous t expressing the current average charge as a percentage of th base period average charge. Referring to the above hypo thetical example, for instance, it can be seen that $80 i 106.7% of $75; i.e., the current average fee for a tonsillec tomy in this case would be 106.7% of what the average fe used to be during the base period.

This would indicate that the price of a tonsillectomy (o the average) has gone up 6.7%. From the foregoing, it i clear that a current average charge identical to the bas period average charge would be indicated by an index valu of 100. If the average charge for some procedure happens t be lower than the base period average charge, the inde value will be less than 100, and the percentage decrease wil be the difference between 100 and the current index value.

To produce an index value for an entire class of service such as surgery or obstetrics, the data for every componen procedure representing that category of service ar aggregated in a manner reflecting the relative frequency with which each procedure is performed. This is done b multiplying the current average charge for each componen procedure by the respective number of services reported fo each procedure during the base period. The sum of thes products is a weighted aggregate value representing how much the specific mix of services sampled within the give category of service during the base period would cost a today's prices. The current index value for that category o service then is obtaincd by reference to the aggregate valu of this same mix of services and procedures at base perio prices.

As a hypothetical example, suppose that base period dat have been compiled for three surgical procedures a follows:

Procedure	Average Charge During Base Period	Number of Services During Base Period
Tonsillectomy	$ 76	1000
Cholecystectomy	$263	500
Hemorrhoidectomy	$180	1000

These are only a few of the procedures included within the surgery category in the index system. For the sake of illustration, however, suppose that the above three procedures are the only components of the surgery category. The weighted aggregate base period (reference) value would be calculated as follows:

(step 1) $ 76 x 1000 = $ 76,000
$263 x 500 = $131,500
$180 x 1000 = $180,000
(step 2) Surgery sum = $387,500
(base period)

If the average charges for these same three procedures, respectively, were $80, $270 and $187 during the most recently completed quarter, the weighted aggregate current value would be obtained by applying the base period service frequencies to these current average charge figures;

(step 1) $ 80 x 1000 = $ 80,000
$270 x 500 = $135,000
$187 x 1000 = $187,000

(step 2) Surgery sum = $402,000
(current)

The current index value for this category of service is computed to express the relationship between the current aggregate value and the base period aggregate value for the same mix of services as follows:

CURRENT/BASE SURGERY RATIO = $402,000 ÷ $387,500 = 1.037;
SURGERY INDEX = 1.037 x 100 = 103.7

This would represent a 3.7% increase in charges for surgery as a generic class of physician services.

The overall charge index for the entire sample of 133 procedures, spanning all of the principal categories of service, is computed in a similar manner. The overall charge index is based upon a ratio of weighted sums which in effect compares the aggregate value of a base period mix of services, taken at current average charges, to the aggregate value of this same mix of services at base period average charges.

Payment indices, reflecting the quantitative relationship of current to base period average payments made to physicians by Pennsylvania Blue Shield, are determined according to computational procedures that are identical to those described above for charge indices. The payment indices also are based upon precisely the same mixes of services and procedures used in establishing the charge indices.

The Charge/Payment Index System is designed to produce both charge and payment indices for selected specific procedures, for each of several generic classes of physician services (surgery, obstetrics and pathology, for example), and for the entire sample of 133 procedures, representing a combination of several different categories of physician services. In addition to raw indices, the system produces derived measures indicating the direction and amount of change in charges and payments observed over both a quarterly and an annual span of time. Thus, for each of the several different kinds of index which can be produced, the system generates the value of the index itself, the quantitative change from the preceding quarter, and the direction and amount of change from the index value for the corresponding quarter one year earlier. All indices and change indicators produced by the system are tracked over time on a quarterly basis.

Data Base

The system, as currently conceived, deals only with charges and payments made under Pennsylvania Blue Shield's Prevailing Fee Program.

Developed in 1965, the Prevailing Fee concept was offered as Pennsylvania Blue Shield's first attempt to pay physicians according to some mechanism other than a fixed fee schedule. It provides a wide range of benefits and determines how much the Blue Shield payment should be for a given service on the basis of usual, customary or reasonable (UCR) criteria.

The central concept in a UCR approach is that each physician should be paid the entire fee he charges for a particular service, provided it does not exceed his own usual charge for this service, nor exceed the customary fee for the same service performed by physicians of similar training and experience practicing in similar areas. The customary fee for a service is calculated to provide full payment for at least 90% of the charges submitted to Blue Shield under this plan. The reasonable criterion is employed in cases for which there may be unusual circumstances to justify charges and payments higher than the usual or customary.

Blue Shield participating doctors in Pennsylvania accept payment under the Prevailing Fee Program as payment in full for the services covered by a subscriber's agreement.

Claims submitted and processed under the Prevailing Fee Program thus provide a base of information in which there is a realistic reflection of actual charge patterns throughout the state. The files containing these claims data, derived from Blue Shield Doctor Service Reports submitted under the Prevailing Fee Program and processed according to UCR standards, comprise the most reliable and comprehensive repository of information available on the "going rates" for physician services in Pennsylvania. As such, they may be taken to be a reasonably valid and appropriate source of data for an ongoing study of Pennsylvania physicians' charges and subsequent Blue Shield payments.

Experience with the Charge/Payment Index System during the two-year test and evaluation period was quite satisfactory. The system currently is in a quasi-operational status, with quarterly index reports being produced and distributed to Pennsylvania Blue Shield executives on a regular basis. Developmental efforts, however, are continuing — aimed at further refinement and expansion of the Charge/Payment Index System.

Objectives for future expansion include indexes by physician specialty and by particular geographic regions of the state. □

PENNSYLVANIA MEDICINE continuing education

INTERMITTENT COURSES

Listed below are courses of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, contact the director at the address given in the course listing.

GASTROENTEROLOGY

Philadelphia; March 3 - April 7, 1972
AMA — Gastroenterology Seminar (Basic Concepts in the Modern Diagnosis & Management); at Hahnemann; 3½ hrs. per day; 1 day per week; 6 weeks; 21 hrs. AAGP credit requested; fee = $60. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

GENERAL MEDICINE

Allentown Hospital; September 9, 1971 - June 8, 1972
AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; 1 day ea. mo.; 3 hrs. ea. day; 30 hrs. AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Altoona Hospital; October 7, 1971 - May 18, 1972
AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; 2 days ea. mo.; 2 hrs. per day; AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 16, 1971 - May 18, 1972
AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; at St. Luke's Hosp.; 1 day ea. mo.; 3 hrs. per day; AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford; October 19, 1971 - May 16, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; at Penn Hills Club; third Tues. ea. mo. except Dec. and Jan.; 18 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

DuBois Hospital; February 10 - April 13, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; Thurs. ea. week; 30 hrs. AAGP credit requested, fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

East Stroudsburg; October, 1971 - April, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and M.C. of Pa.; at General Hosp. of Monroe County; 3 hrs. per day; 1 day per mo.; 6 mos.; 18 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Gettysburg; January 11 - April 19, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; at Annie Warner Hospital; every-other week, alternating Tues. and Wed.; 24 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Hanover General Hospital; October 20, 1971 - May 18, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; one ea. mo. except Jan. and Feb.; 12 hrs. AAGP credit requested. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

CODE KEY
S—Designed for full-time specialists
AAGP—American Academy of General Practice
ACGP—American College of General Practitioners in Osteopathic Medicine and Surgery
AMA—AMA Accredited Educational Institution (Eligible for AMA Physician's Recognition Award Credit)
PMS—Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
M.S. Hershey—Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Pitt—University of Pittsburgh School of Medicine
Penn State—Pennsylvania State University
Temple—Temple University School of Medicine
U. of Pa.—University of Pennsylvania School of Medicine
MCP—The Medical College of Pennsylvania

Hazleton State General Hospital; September 1 - June 1
AMA (required credit) — A Program of Continuing Medical Education; by U. of Pa.; 1½ hrs. ea. day; Thurs. ea. week; 36 weeks; 54 hrs. total; 40 hrs. AAGP credit approved. Contact Robert Gunderson, M.D., D.M.E., Hazleton State Gen. Hosp., Hazleton 18201.

Kittanning; December 2 - 16, 1971
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; at Armstrong County Memorial Hosp.; every Thurs.; 6 hrs. AAGP credit requested, fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Lancaster General Hosp.; September 7, 1971 - May 30, 1972
Continuing Education Program; 1 day per week; 3 hrs. per day; 29 days; AAGP credit requested; fee = none. Contact John H. Esbenshade, Jr., M.D., Dir. Med. Educ., Lancaster General Hosp., 555 N. Duke St., Lancaster 17604.

Lancaster Osteopathic Hospital; September 23, 1971 - May 25, 1972
AMA — Continuing Education Program; by Hahnemann; 2 hrs. per day; 1 day per week; 17 weeks; 34 hrs. AAGP and ACGP credit requested. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Lebanon; November 3, 1971 - May 2, 1972
AMA — A Continuing Medical Education Program; by Jefferson and Penn State; at Quentin Riding Academy; 1 day every-other mo.; 2 hrs. per day; 8 hrs. AAGP credit requested; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lewistown Hospital; February 9 - April 12, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; every Wed.; 30 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Lock Haven Hospital; October 20, 1971 - April 19, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; first and third Wed. except holidays; 30 hrs. AAGP credit requested, fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Meadville; September 1, 1971 - May 3, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS; at Meadville City Hosp.; first Wed. ea. mo.; 18 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Philadelphia; September 15, 1971 - May 17, 1972
Continuing Medical Education Seminars; at Methodist Hospital; 1 day ea. mo.; 2 hrs. per day; 18 hrs. AAGP credit requested; fee = none. Contact John N. Giacobbo, M.D., D.M.E., Methodist Hosp., 2301 S. Broad St., Philadelphia 19143.

Philadelphia; October 13 - December 1, 1971
Recent Advances in Medicine; at Temple; 1 day ea. week; 4½ hrs. ea. day; AAGP credit requested; fee=$75. Contact Albert J. Finestone, M.D., Dept. of Med., Temple, Broad & Ontario Sts., Philadelphia 19140.

Pittsburgh; August 5, 1971 - June 22, 1972
Post Graduate Medical Education Lectures; at St. Margaret Memorial Hosp.; first, second and third Thurs. ea. mo. except July; 1 hr. per day; AAGP credit requested; min. enrollment=30; fee=none. Contact Paul W. Dishart, M.D., D.M.E., St. Margaret Memorial Hosp., 265 - 46th St., Pittsburgh 15201.

Pittsburgh; September 2, 1971 - June 15, 1972
Psychiatry Seminars in Family Practice; at St. Margaret Memorial Hosp.; 1 day ea. week; 2 hrs. ea. day; 32 weeks; min. enrollment 6; AAGP credit requested; fee=$50 for ea. 10-week series. Contact Paul W. Dishart, M.D., D.M.E., St. Margaret Memorial Hosp., 265 46th St., Pittsburgh 15201.

Pittsburgh; July 14, 1971 - June 23, 1972
Post Graduate Medical Education Lectures —Family Practice; at St. Margaret Memorial Hosp.; every Wed.; 1 hr. ea. day; AAGP credit requested; min. enrollment=20; fee=none. Contact Paul W. Dishart, M.D., D.M.E., St. Margaret Memorial Hosp., 265 - 46th St., Pittsburgh 15201.

Pottsville Hospital; September 2, 1971 - June 1, 1972
AMA —A Program of Continuing Medical Education; by Jefferson and Penn State; first Thurs. ea. mo.; 2 hrs. ea. day; 20 hrs. AAGP credit approved; fee=none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

St. Marys; September 26, 1971 - March 26, 1972
Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust); by PMS, Pitt and Western Pa. RMP; at Andrew Kaul Memorial Hosp.; forth Sun. ea. mo. except December; 21 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Sellersville; September 22, 1971 - June 15, 1972
AMA —Continuing Education Program; at Grand View Hosp.; by Hahnemann; 2 hrs. per day; 1 day per mo.; 9 months; 18 hrs. AAGP and ACGP credit requested. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Sharon General Hospital; October 20, 1971 - March 1, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; first and third Wed. ea. mo.; 30 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Somerset Community Hospital; Fourth Tuesday of each month
A Program of Continuing Medical Education; by Western Pa. RMP and the Regional PG Medical Faculty Project of Lee Hospital, Johnstown; 2 hrs. ea. day; 24 hrs. AAGP credit requested ea. year.

Contact William W. Ayres, M.D., Pathologist, Somerset Community Hosp. 225 S. Center Ave., Somerset 15501.

Tunkhannock; March 8 - May 10, 1972
Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust); by PMS and Greater Delaware Valley RMP; at Tyler Memorial Hosp.; second Wed. ea. mo.; 9 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Uniontown Hospital; September 22, 1971 - February 23, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; every-other Wed. except Dec. and Jan.; 24 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Wellsboro; September 15, 1971 - March 15, 1972
Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust) by PMS and Susquehanna Valley RMP; at Soldiers and Sailors Memorial Hosp.; third Wed. every-other mo.; 12 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Williamsport Hospital; September 10, 1971 - March 10, 1972
AMA — A program of Continuing Medical Education; by Jefferson and Penn State; second Fri. ea. mo. except Jan.; 3 hrs. ea. day; 18 hrs. AAGP credit requested; fee=none. Contact John H. Killough, Ph. D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

INTERNAL MEDICINE

Philadelphia; October 6, 1971 - May 31, 1972
AMA — Internal Medicine Reviews; at Hahnemann; 3 hrs. ea. day; 1 day ea. week; 32 weeks; 96 hrs. AAGP credit approved; $175 fee ($50 ea. sub-specialty — Hematology & Medical Oncology, October 6 to November 17; Gastroenterology, November 24, 1971 to February 9, 1972, Dermatology & General Topics, February 16 to April 19; Cardiology, April 26 to May 31). Contact Mrs. Sage Cordell, Asst. Dir. PG Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Pittsburgh; September 13 - October 15, 1971
AMA — Internal Medicine Review Course; by Pitt and Amer. Coll. of Physicians; at Pitt; 3 hrs. a day; 2 day ea. week; 5 weeks; 33 hrs. AAGP credit requested; $50 fee. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt. Scaife Hall, Pittsburgh 15213.

MALIGNANT DISEASE

Reading; Fourth Tuesday ea. month
Tumor Conference; at Community General Hospital. Contact Harold I. Farber, M.D., Dir. Tumor Clinic, Community Gen. Hosp., 145 N. Sixth St., Reading 19601.

NEUROLOGY

Norristown State Hospital; September 13, 1971 - May 8, 1972
Intensive Review of Neurology; 1¼ hrs. per day; 1 day per week; 30 weeks; min. enrollment 8; fee=$100. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

PHARMACOLOGY

Philadelphia; September 27, 1971 - January 24, 1972
AMA — Experimental Design, Statistics and Fortran; at Hahnemann; 2 hrs. per day; 2 days per week; 15 weeks; 58 hrs. AAGP credit requested; fee=$300. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia General Hospital; September 29, 1971 - May 31, 1972
AMA — Current Concepts in Clinical Pharmacology; by Hahnemann and American Society for Clinical Pharmacology and Therapeutics; 3 hrs. per day; 1 day per week; 35 weeks; 105 hrs. AAGP credit requested; fee=none. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

PSYCHIATRY

Allentown Osteopathic Hospital; September 22 - December 8, 1971
AMA — Adolescence and the Youth Culture; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks; 20 hrs. AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Easton Hospital; September 27, 1971 - June 26, 1972
AMA — Psychiatry in Medical Practice; by Hahnemann; 1½ hrs. per day; 1 day per mo.; 9 mos.; 13½ hrs. AAGP credit requested; fee=none. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Norristown State Hospital; September 10, 1971 - May 12, 1972
S — Intensive Review of Psychiatry; 1¼ hrs. per day; 1 day per week; 31 weeks; min. enrollment=8; fee=$100. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown State Hospital; October 1 - December 10, 1971
S — Group Therapy; 1½ hrs. per day; 1 day per week; 10 weeks; min. enrollment=8; fee=$50. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown State Hospital; January 7 - February 18, 1972
S — Management of Adolescent Behavorial Disorders; 1½ hrs. per day; 1 day per week; 7 weeks; min. enrollment=8, fee=$30. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown State Hospital; March 3 - May 19, 1972
S — Family Therapy II; 1½ hrs. per day; 1 day per week; 10 weeks; min. enrollment=8; fee=$50. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Philadelphia; September 7, 1971 - June 6, 1972
S/AMA — Advances in Psychiatry and Behavorial Sciences; by Institute of Pa. Hosp. and U. of Pa.; at the Institute; 1½ hrs. ea. day; 1 day ea. mo.; 10 mos.; fee=$50. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; September 15 - November 17, 1971
AMA — Sexual Problems in Medical Practice; by Hahnemann; 2 hrs. ea. day; 1 day ea. week; 10 weeks; AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 4 - December 6, 1971
S/AMA — Family Therapy; by the Institute of Pa. Hosp. and U. of Pa.; at Philadelphia Child Guidance Clinic; 2½ hrs. per day; 1 day per week; 10 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 6 - December 8, 1971
S/AMA — Marital Therapy; by the Institute of Pa. Hosp. and U. of Pa.; at Marriage Council of Philadelphia; 2½ hrs. ea. day; 1 day per week; 10 weeks; fee =$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 6, 1971 - February 16, 1972
AMA — Psychiatric Problems of Children; by Hahnemann; 2 hrs. per day; 1 day per week; 18 weeks; 36 hrs. AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Edu. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 13, 1971 - May 17, 1972
AMA — Seminars in Psychotherapy: Short-term, Crisis & Supportive Therapies; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks per seminar; AAGP credit requested; fee=$150 for 30 weeks, $75 for 10 weeks. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; January 10 - March 13, 1972
S/AMA — Behavior Therapy; by the Institute of Pa. Hosp. and U. of Pa.; at Hospital of U. of Pa.; 2 hrs. per day; 1 day per week; 10 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 10 - February 14, 1972
S/AMA — Psychopharmacology; by the Institute of Pa. Hosp. and U. of Pa.; 1½ hrs. per day; 1 day per week; 6 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 11 - February 29, 1972
S/AMA — Treating Today's Adolescent; by the Institute of Pa. Hosp. and U. of Pa.; 1½ hrs. per day; 1 day per week; 8 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March 22 - May 24, 1972
AMA — Adolescence and the Youth Culture; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks; AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; March 22 - May 24, 1972
S/AMA — Advanced Marital Therapy — Treating Sexual Incompatibility; by the Institute of Pa. Hosp. and U. of Pa.; at Marriage Council of Philadelphia; 2½ hrs. per day; 1 day per week; 10 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

OTHER COURSES
code
C—Continuous (Consecutive Days)
O—One Day or Less
PG—Postgraduate Traineeship
M—Multiple Sites (Circuit)

ALLERGY

September 6 - October 29, 1971; Philadelphia (repeat February 7 - March 13, 1971 and May 1 - June 23, 1972)
PG/AMA — Clinical Immunology Tutorial Course; at Hahnemann; 7-8 hrs. per day; 40 days; fee = $500. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

ARTHRITIS & RHEUMATISM

Continuous; Philadelphia
PG/AMA — Rheumatology Tutorial Course; at Hahnemann; 6-7 hrs. per day; 2 days per week; 4 weeks; fee = $150. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CARDIOVASCULAR DISEASE

Continous (2 or 3 weeks in each sub-section); Philadelphia

PG/AMA — Tutorial Courses; Fluid and Electrolyte Metabolism; Hypertension (Clinical & Laboratory); Dialysis; Cardio-Hemodynamics; Cardiac Care Unit; Electrophysiology; Vector-Electrocardiography and Cardiovascular Pharmacology; Atherosclerosis and Lipid Metabolism; Phono-Echo; Clinical Cardiology and Cardiovascular Surgery; at Hahnemann; 6, 7, 8, or 9 hrs. per day; 10 or 15 days; fee = $300 ea. sub-section. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

September 21 - 25, 1971; Philadelphia

C/AMA — Cardiac Arrhythmias (Pathophysiology, Pharmacology and Treatment by Hahnemann; at Marriott Motor Hotel; 7 hrs. ea. day; 4½ days; 30 hrs. AAGP credit approved; $175 fee. Contact Mrs. Sage Cordell, Asst. Dir., Cont. Educ., Hahnemann; 230 N. Broad St., Philadelphia 19102.

September 27 - 28, 1971; Philadelphia

C/AMA — Current Topics in Cardiopulmonary Disease - 1971; Evolving Concepts in Coronary Artery Disease; by American College of Cardiology; at Temple. Contact Miss Mary Ann McInerny, Dir., Dept. of Cont. Educ., American College of Cardiology, 9650 Rockvill Pike, Bethesda, Md. 20014.

December 13-17, 1971; Philadelphia

C/AMA — High Blood Pressure, 1971 (26th Hahnemann Symposium); by Hahnemann; at Sheraton Hotel; 7 hrs. per day; 5 days; 35 hrs. AAGP credit approved; fee = $175. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

April 10-21, 1972; Philadelphia

C/AMA — Core Curriculum-Fundamentals and Applied Clinical Cardiology Seminar; by Hahnemann; 7 hrs. per day; 12 days; 84 hrs. AAGP credit requested; fee = $300. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

July 17-19, 1972, Philadelphia

C/AMA — Bedside Diagnosis of Heart Disease; by Hahnemann; 7 hrs. per day; 3 days; 21 hrs. AAGP credit requested; fee = $125. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CHEST DISEASES

Continuous (4 weeks in each sub-section); Philadelphia

PG/AMA — Tutorial Courses: Clinical Pulmonary Disease; Inhalation Therapy; Pulmonary Physiology; Respiratory Intensive Care; at Hahnemann; 7, 8, or 9 hrs. per day; 20 days; fee = $350. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 4-15, 1971; Wilkes-Barre General Hospital
December 6-17, 1971; Philadelphia (Hahnemann)
March 14-25, 1972; Allentown Hospital

M/AMA — A Workshop in Respiratory Intensive Care; by Greater Delaware Valley RMP: 2 weeks; 5 days ea. week; 70 hrs. AAGP credit approved. Contact F. R. Johnston, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 24 - 28, 1971; Philadelphia

C/AMA — 37th Annual Fall Scientific Assembly; American College of Chest Physicians; at Sheraton Hotel; 31 credit hours; Fee: Members = no charge; non-members with M.D. degree prior to 1961 = $65 (armed service or US PHS = $45); non-members with M.D. degree received after 1960 = $45 (armed service or US PHS = $25). Contact Bradford W. Claxton, M.Ed., Dir. Cont. Educ., Amer. Coll. of Chest Phys., 112 E. Chestnut St., Chicago, Ill. 60611.

November 1-12, 1971; Philadelphia (repeat February 28 — March 10, 1972)

PG — Bronchoesophagology; at Temple; $350 fee; planned for chest physicians, thoracic surgeons, anesthesiologists and gastroenterologists. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

November 10, 1971; Franklin

O/AMA — A program of Continuing Medical Education; by Jefferson and Penn State; at Franklin Hospital and Voyager Motor Inn; 3 hrs. AAGP credit approved; fee = $10. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 3-6, 1972; Philadelphia

C/AMA — Pulmonary Care in the Seventies (27th Hahnemann Symposium); by Hahnemann; at Marriott Motor Hotel; 5-6 hrs. per day; 4 days; 25 hrs. AAGP credit approved; fee = $175. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

EMERGENCY MEDICINE

September 15, 1971; Bloomsburg State College

O — Malpractice in the Emergency Room; by PMS; 3 hrs. AAGP credit requested; min. enrollment=40; fee=$10. Contact PMS (Emergency Med. Service), 20 Erford Rd., Lemoyne 17043.

October 4-15, 1971; Philadelphia (repeat February 7-18, 1972 and May 2-13, 1972)

PG/AMA — Emergency Room Tutorial Course; by Hahnemann; 8 hrs. ea. day; 10 days; fee=$400. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

March 11, 1972; Hershey

O/AMA — Emergency Room Techniques; by PMS and Pa. Trauma Committee of ACS; at Hershey; 6 hrs.; min. enrollment=50; fee=$10. Contact PMS (Emergency Med. Service), 20 Erford Rd., Lemoyne 17043.

ENDOCRINOLOGY

September 6 - October 1, 1971; Philadelphia (repeat March 6-31, 1972)

PG/AMA — Endocrinology and Metabolism Tutorial Courses; at Hahnemann, 7-8 hrs. per day; 20 days; fee=$350. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

GASTROENTEROLOGY

April 15, 1972; Hershey

O — Seminar on Gastroenterology; by PMS and Pa. Osteopathic Assoc.; at M.S. Hershey; 6 hrs. AAGP and ACGP credit requested; fee=$100; min. enrollment=20. Contact PMS (PMS-POA Seminar), 20 Erford Rd., Lemoyne 17043.

GENERAL MEDICINE

Continuous; Philadelphia

PG/AMA — Tutorial Courses: Basic General Medicine (7-8 hrs. per day; 60 days; fee=$700); Critical Care Medicine (8-9 hrs. per day; 10 days; fee=$300) at Hahnemann. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

As Requested, 1971; Philadelphia

PG — Acute Care Medicine Fellowship (retraining program for women physicians); by M.C. of Pa.; 6 hrs. per day; 1 yr. duration. Contact Ethel Weinberg, M.D., Assoc. Dean, MCP, 3300 Henry Ave., Philadelphia 19129.

Third Wed. ea. mo.; Aliquippa-Rochester Hospitals (rotation)
Fourth Thurs. ea. mo.; Altoona Hospital
First Tues. ea. mo.; Greensburg (Westmoreland Hosp.)
First Thurs. ea. mo.; Johnstown (Conemaugh Valley Mem. Hosp.)
Second Tues. ea. mo.; Natrona Heights (Allegheny Valley Hosp.)
Last Mon. ea. mo.; Uniontown Hospital
First Wed. ea. mo.; Washington Hospital

M — Diagnosis and Management of Hypertension; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin P. Shapiro, M.D., Project Dir., 501 Flannery Bldg., 3530 Forbes Ave., Pittsburgh 15213.

September, 1971; Butler
September, 1971; Erie
October, 1971; Altoona
October, 1971; Greensburg
October, 1971; Scranton
October, 1971; Williamsport
December, 1971; Harrisburg
January, 1972; Allentown
January, 1972; Norristown

M — The Physician and Addictive Disease; I PMS, PAGP, Pa. Dept. of Health and Pa. Dept. Welfare; 8 hrs. AAGP credit requested; min. e rollment=10, fee=$10. Contact PMS, 20 Erfo Rd., Lemoyne 17043.

November 8-11, 1971; Lancaster

C/AMA — Clinical Therapeutics 1971: Eme gency Medicine; by PMS, U. of Pa., Temple, M.(of Pa. and Hershey; at Host Farm Resort Motel; 2 hrs. AAGP credit requested; min. enrollment=2 fee=$25. Contact PMS (Scientific Assembly), 2 Erford Rd., Lemoyne 17043.

December 13-17, 1971; Philadelphia

C/AMA — High Blood Pressure - 1971; by Hal nemann; at Sheraton Hotel; 8 hrs. ea. day; 4½ days; 35 hrs. AAGP credit requested; $125 fe Contact Mrs. Sage Cordell, Asst. Dir., Cont. Educ 230 N. Broad St., Philadelphia 19102.

May 4-6, 1972; St. Davids

C — Annual Main Line Conference of Bry Mawr Hosp.; at Treadway Inn; 2½ days; 15 hr AAGP credit approved; fee=$35. Contac Theodore J. Berry, M.D., DME, Bryn Mawr Hosp Bryn Mawr 19010.

INTERNAL MEDICINE

January 3-7, 1972; Philadelphia

C/AMA — Workshops in the Physiology, Patho physiology and Diagnosis of Disorders o Electrolyte and Acid-Base Metabolism; by Amer Coll. of Physicians; at Hospital of the U. of Pa Fee: Members and F.A.C.P. =$80, non-member = $125, candidate members and ACP Latin Ameri can Fellows = $40. Contact Registrar, Post graduate Courses, Amer. Coll. of Physicians, 420 Pine St., Philadelphia 19104.

March 20-24, 1972; Philadelphia

C/AMA — Specifically Treatable Diseases (Em phasizing Pathophysiology and Early Clinica Findings); by Amer. Coll. of Physicians; at Penn sylvania Hosp. and U. of Pa.; Fee: Members an F.A.C.P.=$80, non-members=$125, candidat members and ACP Latin American Fellows=$4(Contact Registrar, Postgraduate Courses, Amer Coll. of Physicians, 4200 Pine St., Philadelphi 19104.

MALIGNANT DISEASE

October 4-29, 1971; Philadelphia (repea November 1-26, 1971, February 7 - March 3, 1972 and April 3-28, 1972)

PG/AMA — Hematology and Medical Oncolog Tutorial Course; at Hahnemann; 8-9 hrs. per day 20 days; fee=$400. Contact Frederick K. Heath M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

NEPHROLOGY

June 5-7, 1972; Philadelphia

C/AMA — Nephrology for the Practicing Physician; by Hahnemann; at Holiday Inn; 7 hrs. ea day; 3 days; 21 hrs. AAGP credit requested; $12 fee. Contact Mrs. Sage Cordell, Asst. Dir., Cont Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

RADIOLOGY

Continuous; Philadelphia

PG/AMA — Cardiac Radiology; at Hahnemann; 8 hrs. per day; 5 days per week; 3 weeks; fee = $300. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Physicians' self-assessment programs listed

Listed below are the various self-assessment programs that are available to members of Pennsylvania Medical Society. The major aspects of each program are listed. If you wish further information or a copy of the self-assessment material, the name of the person to contact is also listed.

Anesthesiology

Date of Issue: 1969.
Test Area: Clinical problems.
Characteristics: Self-Evaluation Program designed in conjunction with the National Board of Medical Examiners. Each member retains a set of marked answers that he grades himself.
Available: To all physicians.
Fee: $20 for members of American College. $30 non-members.
Contact: Self-Evaluation Program, American College of Anesthesiologists, 515 Busse Highway, Park Ridge, Ill. 60068.

Clinical Pathology

Date of Issue: Late February, 1971 on a trial basis at national meeting. Subsequent two-year period will see release of additional exams.
Test Areas: Initial areas— pathologic anatomy (surgical pathology), clinical chemistry Test A (emphasizing technical applications), clinical chemistry Test B (emphasizing clinical applications).
Additional areas shortly— Microbiology, Hematology, Immunohematology.
Final areas (over a two-year period)— remainder of the major laboratory specialities.
Characteristics: Examination conditions (fixed time, no books, proctor, etc.)
Scaled scores on basis identical with SAT with a mean of 800.
Each participant will know his own scaled score and will be graded against his own peer group. He will be provided with the answers to the questions, perhaps some comment on the answer, and references to readily available publications.
Fee: Between $15 and $20.
Available: To local or regional societies provided they will administer the examination under the same uniform conditions.
Contact: George J. Carroll, M.D., Commission on Continuing Education, The American Society of Clinical Pathologists, 710 S. Wolcott Avenue, Chicago, Ill. 60612.

Internal Medicine
American College of Physicians

Date of Issue: 1967. Next prospectus release date to be announced.
Test Area: Various fields of internal medicine.
Characteristics: Next self-assessment program will include test materials, answer sheets, and (in sealed envelope) the answers and a bibliography.
Available: To all physicians.
Fee: $20 for ACP members, residents or fellows in training. $40 for non-members. $7 for ACP candidate members.
Contact: Edward C. Rosenow, Jr., Executive Vice President, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Obstetrics and Gynecology

Date of Issue: May, 1971 (at annual clinical meeting).
Test Area: Clinical Obstetrics.
Characteristics: This project is being undertaken in cooperation with the National Board of Medical Examiners. Each participant will receive a score indicating how he stands in relation to others taking the exam.
Available: At present primarily to limited number of Fellows of the College and only at the Annual Clinical Meetings of the College.
Fee: $25
Contact: Michael Newton, M.D., Director, The American College of Obstetricians and Gynecologists, 79 W. Monroe St., Chicago, Ill. 60603.

Orthopaedic Surgery

Date of Issue: 1963.
Special Note: The Orthopaedic In-Training Examination (designed for residents) is the only program available to members of the Academy at present. A committee is at work on a self-assessment program which probably will not be available until late 1971.
Fee: $20 for each resident. $30 for each practicing orthopaedic surgeon.
Contact: Charles V. Heck, M.D., Director, American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Ill. 60611.

Pathology

Date of Issue: 1949.
Test Areas: Office Laboratory, Small Hospital Laboratory, Large Hospital Laboratory, and Laboratories in Teaching Institutions.
Characteristics: Office Laboratory Peer Evaluation Program is endorsed by American Society of Internal Medicine. Test materials are mailed quarterly. Yearly enrollment— fee $80.
Small Hospital Laboratory (Basic) meets requirements for Medicare and most state licensure programs. Fee $155 (10% reduction for CAP members).
Large Hospital Laboratory (Comprehensive— 4 parts) meets and exceeds the proficiency testing equivalency requirements in "chemistry", "hematology" and "blood banking". Fees: $95 to $205 (10% reduction as above).
Teaching Institution Laboratory (Special— 2 parts) meets the proficiency testing equivalency requirements in the specific areas of Microbiology and "Serology". Fees: $95 and $90. (10% reduction as above).
You receive your results, referee values, selected Youden plots and participant manual.
Available: To both members and non-members of CAP.
Contact: Mr. Edward J. Stygar, Jr., Director of Administrative Services, College of American Pathologists, 230 N. Michigan Ave., Chicago, Ill. 60601.

Pediatrics

Date of Issue: May, 1970
Characteristics: Examination booklets, answer sheets, correct answer key, and bibliography are mailed upon receipt of request and check.
Available: To both members and non-members of Academy.
Fee: $25 (make check payable to American Academy of Pediatrics).
Contact: Gerald E. Hughes, M.D., Director, Dept. of Educational Affairs, American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Ill. 60204.

Psychiatry

Date of Issue: General tests— available at present. Second Self-Assessment Program— Spring of 1972.
Characteristics: Tests, correct answers and the accompanying

bibliography are mailed upon receipt of request and check.
Available: To both members and non-members of APA.
Fee: $15 for general tests. Self-assessment program fees announced with prospectus.
Contact: Hugh T. Carmichael, M.D., Director, Office of Continuing Education for Psychiatrists, American Psychiatric Association, 1700 18th St. N.W., Washington, D.C. 20009.

Surgery

Date of Issue: October, 1971.
Test Area: General Surgery.
Characteristics: Details will be explained in prospectus "Surgical Education Self-Assessment Program."
Available to: All physicians who consider surgery their major area of endeavor.
Contact: Harold A. Zintel, M.D., Asst. Dir., American College of Surgeons, 55 E. Erie St., Chicago, Ill. 60611.

Electrocardiography

Date of Issue: May, 1971
Test Area: Electrocardiography and the clinical aspects of myocardial infarction.
Characteristics: Four programmed self-instruction courses published as individual communications in "Chest" and now collated into a single teaching unit of 52 pages.
Available: To all physicians.
Fee: $2.00 each; 25-50 copies = $1.80 each; 50-100 copies = $1.60 each; 100 and over = $1.50 each.
Contact: American College of Chest Physicians, 112 E. Chestnut Street, Chicago, Illinois 60611.

Family Practice

Date of Issue: April, 1971
Test Area: Three parts as follows— diagnosis, differential diagnosis, and preventive medicine and therapy.
Characteristics: Examination is designed for individuals in practice of general, clinical medicine. Answers are supplied with exam: approximately one-fourth of questions are annotated and/or supplied with bibliography.
Available: To all physicians.
Fee: $17.50 non-members of Philadelphia County Medical Society.
Contact: Self Evaluation Committee, Philadelphia County Medical Society, 2100 Spring Garden Street, Philadelphia, Pa. 19130.

Radiology

Date of Issue: November, 1971.
Test Areas: Chest (first test); subsequent tests on gastrointestinal system, genitourinary system, skeletal system and heart and neck (at 3-month intervals).
Characteristics: Self-evaluation and continuing education program kits will contain questions, roentgenograms, and (after completion) an answer syllabus.
Available to: Any physician.
Fee: $45 - ACR members; $35 - residents or fellows in training; $65 - non-members.
Contact: Mr. William K. Melton, American College of Radiology, 6900 Wisconsin Ave., Chevy Chase, Md. 20015.

Ophthalmology

Date of Issue: May 6, 1972
Test Area: Resident In-Service Training Examination
Characteristics: The American Academy of Ophthalmology and Otolaryngology is trying this method of encouraging self-assessment by the practicing ophthalmologist instead of offering a separate self-assessment program for practitioners. Examinations will be offered in 135 centers in the United States and Canada. Scores of practicing ophthalmologists would be returned to them individually and secretly, together with comparative scores of peers.
Fee: Yet to be determined.
Available: All practicing ophthalmologists
Contact: Melvin L. Rubin, M.D., Department of Ophthalmology, University of Florida College of Medicine, Gainesville, Fla. 32601.

Otolaryngology

Three choices available (all developed in cooperation with t
American Academy of Ophthalmology and Otolaryngology);

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available to interested practitioners on a volunta
basis as a self-assessment examination. Results a
machine graded, computer analyzed, and returned
participant. Fee to be determined.

II. 1971 Self-Evaluation Examination— A.A.O.&O. annu
meeting, Sept. 1971.
Consists of six different branching type written si
ulation exercises— 2 in otology, 2 in head and ne
surgery, 2 in plastic and reconstructive surge
Results will be machine graded, computer analyze
and available to participant 24 hours later. No fee.

III. 1972 Self-Improvement Program— beginning Febr
ary, 1972.
A four-part program consisting of three "patient
the month" problems (to be mailed February 15, M
15 and August 15) and self-assessment examination
November. The problems will be self-scoring; the co
fidential results of the examination will be mailed aft
computer analysis.

Contact: George F. Reed, M.D., Department of Otolaryngolog
State University of New York, 750 East Adams Stree
Syracuse, N.Y. 13210.

meetings

National Medical Association, **August 8-12**, Philadelphi
Pa.

"Contemporary Trends in Employee-Management Rel
tions," sponsored by Pennsylvania State Universit
August 9-13, Seven Springs Resort, Champion, Pa.

Annual Symposium on Sports Medicine, **August 12 and 1**
Germantown Academy, Fort Washington, Pa.

Annual American Medical Association Congress on Oc
cupational Health, **August 29-30**, Jackson Lake Lodg
Grand Teton National Park, Wyoming.

American Hospital Association, **August 23-26,** Chicag
Ill.

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weeks beginning **September 8** on Wednesday evenings. Co
tact: Dr. Allen M. Kratz, Philadelphia College of Pharmac
and Science, 43rd St. and Kingsessing Ave., Philadelph
19104.

American Electroencephalographic Society and th
American Society of EEG technologists (ASET), **Septembe
13-18,** Hotel Radisson South, Bloomington, Minn. A cours
on current practice of clinical electroencephalography an
scientific sessions. Contact: Mrs. Margaret H. Henry, exe
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Grove Rd., Willoughby Hills, Ohio 44094.

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Surgical Treatment of Coronary Sclerosis

Part 1

William H. Sewell, M.D., chief of cardiac surgery, Guthrie Clinic, and Robert Packer Hospital, Sayre, is questioned by William G. Leaman, Jr., M.D.

What type of coronary patient can be helped by surgery?

We feel we can help the patient who would be in the good risk group and who has arteriographically demonstrated constrictions of 75 percent or worse in main coronary arterial trunks, such as the right, anterior descending, or circumflex arteries. We consider surgery indicated if two or more main trunks are involved to this extent, whether collateral circulation is present or not. It is not indicated if a single major trunk is completely occluded with good collateral development. It is usually indicated by a single tight constriction with only meager collateral development. In actual practice, most surgical patients have two or more major trunks involved.

What do you mean by a "good risk group"?

Such a patient is one with an estimated physiologic age under about sixty-five who is not more than ten pounds overweight, who has not smoked for a month, and who is free of organ damage that would influence the risk of major surgery.

What is the operative mortality in the good risk group?

It has been consistently reported from major centers doing coronary surgery to be under five percent. We lost only two of seventy-nine cases.

Does the ventricular function influence the surgical risk?

Even a patient with very poor ventricular function can be accepted in the good risk group if there is good reason to believe that surgical treatment will improve the function markedly.

Does surgery offer any hope for patients who do not quality for your good risk group but have only a dismal prognosis on medical management?

There have been a few dramatic salvages of such patients. However, operative risks have been reported as high as 30 to 75 percent in these cases. Unfortunately, such risks discourage referring cardiologists, hospital teams, and prospective patients; and I believe they are better avoided until the place of surgery in the management of coronary disease becomes more firmly established.

What are your indications for coronary arteriography?

It is indicated to establish or rule out the diagnosis of coronary sclerosis in most patients under the age of 65 or 70 thought to have coronary disease, but who have not proved this diagnosis by having a transmural infarction or a 1.5 mm. horizontal ST depression during exercise. It is indicated on surgical candidates, which includes all patients who are or could be in the good risk group and who have a definite or suspected diagnosis of coronary disease.

Is coronary arteriography dangerous?

The risk should be no greater than for any other angiographic procedure.

How soon can coronary arteriography be done after a myocardial infarction?

We recommend waiting two to four months, unless emergency surgery is being considered.

What operations do you use?

Usually we do a single or doub saphenous vein graft from the aorta t distal coronary arteries, resection of ventricular aneurysm, and oc casionally both. A mammary arter usually can be anastomosed to the an terior descending or right coronary a teries if the saphenous veins ar unusable.

What do you think of endarterectomy

I am watching the reports with in terest. So far we have successfull anastomosed vein grafts to the poster or descending or other distal righ coronary branches for patients i whom some surgeons would choos endarterectomy. My tentative conclu sion is that the vein grafts are more re liable.

Does the clinical picture influence th indications for surgery?

Only if the arteriographic indica tions are borderline.

Does this mean you advise surgery fo asymptomatic patients?

Yes, if the arteriographic indica tions are strong. I believe that a patien with tight constriction in a dominan right or proximal anterior descendin coronary artery is likely to have an in farction or arrhythmic death if th lesion is not by-passed.

William G. Leaman, Jr., M.D. Fellow, Council on Clinical Car diology, American Heart Association edited this Brief for the Council o Education and Science, in cooperatio with the Pennsylvania Heart Associa tion.

PENNSYLVANIA MEDICINE cancer forum

The multidisciplinary approach to cancer

Psychological Considerations

The patient faced with the possibility or certainty of having cancer is subject to an emotional strain of unique intensity. Depending somewhat on how well or ill informed he is, there is an almost uniform sense of being in the grip of an implacable, painful, inevitably fatal disease. The other diseases, regardless of their seriousness or incurability, produce far less nervous shock. Whether it be acute infections, diabetes, hypertension, or heart disease; they can always think of someone who has had these conditions and who is alive and well. But they are hard put to comfort themselves with similar examples when cancer is the diagnosis.

Certainly in few other diseases is an understanding of the patient's psychology so important if optimum care is to be provided. The anxiety which is so prominent a feature of the cancer patient is matched by that of the family and the physician as well. Thus the physician must not only secure the cooperation of the patient for treatment and rehabilitation, but must be able to work closely with family, clergy and supportive organizations. All can be helpful to his patient.

W. S. Greene of the University of Rochester has outlined the main factors which determine a patient's psychological reaction to being a cancer victim. First of all is the patient's attitude to cancer. This is determined partly by what he has heard, read, or knows of friends' experiences. He may know of one who has recovered and be hopefully confident, or one who had died and be depressed. In looking for a cause of his disease, guilt feelings are common. He may have been sinful, worked too hard, smoked too much. Often he will discuss these possibilities with his physician and get comfort from reassurance.

The second factor determining psychologic response is the specific signs of the disease itself. Some people can tolerate high levels of discomfort, weakness, and pain. Most patients react poorly to interference with breathing, eating, and defecation. Loss of organs with sexual connotation produces depression and anxiety that may last years. Loss of the anal sphincter can also result in a surgical triumph and a psychological disaster. Visible lesions and disfiguring treatments are associated with distress, while internal lesions that are invisible can often be forgotten by the patient.

Methods available for treatment also affect his thinking. Some welcome surgery if available, while others approach it with great dread. The same is true of their response to the radiation modalities. Chemotherapy usually produces less fear since it is so often associated with the more benign diseases.

Of course the patient's personality has a great deal to do with his psychologic response. The depressed, suspicious, dependent patient will need much support. The attitude towards life will vary with their feeling as to whether they have accomplished their mission in society or still have important goals to reach.

The fifth factor relates to the social resources available to the patient. If he can be kept working at home or in business, if he can be kept in the active social stream, his psychological well-being is tremendously enhanced. If he is a religious person, his minister can give much support. As Greene points out, however, if he has been remiss in his religious duties, this could instead be a source of more anxiety.

Most cancer victims are fearful of the withdrawal of their family and acquaintances. Confinement to a hospital, restricted visitors, orders to stop work are all threats to his emotional stability.

Finally the attitude and personality of the attending physician is an important factor. While some physicians do not wish to treat cancer patients there are others who do and have become quite skillful. Such physicians vary their approach with the personality of the patient. Some patients respond to the omnipotent, paternal doctor while others are comfortable with an intimate, concerned and cautious attitude. Versatility on the part of the physician is of great importance.

It seems clear that among the many variables that must be considered in the management of the patient with cancer, the psychologies of the people involved must receive prime consideration by the physician.

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CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.

obituaries

○ Indicates membership in the Pennsylvania Medical Society at time of death.

Clarence J. McCullough, Washington; University of Pennsylvania School of Medicine, 1914; age 80; died June 7, 1971. He was a member of the American Roentgen-ray Society, the American Academy of Ophthalmology, and a diplomate of the American Board of Ophthalmology and the American Board of Otolaryngology. Dr. McCullough was one of the founders and served as president of the Washington County unit of the American Cancer Society, and president of the Washington County Medical Society. He was chairman of the Board of Trustees of the Pennsylvania Medical Society. His wife and a sister survive him.

○ **Charles Irvine Shaffer**, Somerset; Baltimore Medical College, 1907; age 92; died March 28, 1971. He was a president of the Somerset County Medical Society and a delegate to the Pennsylvania Medical Society for forty-five years. There is no information regarding survivors.

○ **Samuel Sheldon Steffler**, Pittsburgh; University of Pennsylvania School of Medicine, 1911; age 83; died March 25, 1971. He was on the staff of St. Francis General Hospital for the past 60 years. He is survived by his wife and a daughter.

○ **Herbert Unterberger**, Philadelphia; Jefferson Medical College, 1945; age 50; died April 5, 1971. He was director of medicine and surgery at Haverford State Hospital, chief of medicine at Haverford Hospital, and assistant chief of medicine at Philadelphia General Hospital. He was a member of the American College of Physicians, and a fellow in the American College of Cardiology and the American College of Gastroenterology. Survivors include his wife, a son, two daughters, his mother, and a sister.

○ **Charles Ward Bethune,** Pittsburgh; Jefferson Medical College, 1918; age 78; died April 22, 1971. He is survived by his wife and a daughter.

○ **David Beveridge,** Washington; Baltimore College of Physicians and Surgeons, 1906; age 91; died April 20, 1971. A fellow of the American Medical Association, he is survived by his wife.

○ **Frederick Webster Byrod,** Lewisberry, Medico-Chirurgical College, 1915; age 79; died April 25, 1971. He is survived by his wife, four daughters, and three step-daughters.

○ **Marlin Shimpff Cargill,** Somerset; Temple University Medical School, 1934; age 66; died April 22, 1971. He was a past president of the Somerset County Medical Society. Surviving are his wife and two daughters.

○ **Hyman Seymour Denberg,** Pittsburg; University of Pennsylvania School of Medicine, 1935; age 60; died April 22, 1971. Survivors include his wife, two daughters, and a son.

○ **Matthew M. Douglas,** Harrisburg; University of Buffalo School of Medicine, 1926; age 75; died April 26, 1971. He is survived by his wife, a daughter, a son, and two sisters.

○ **W. Frank Gemmill,** York; University of Maryland, 1913; age 84; died May 11, 1971. He was a diplomate of the American Board of Surgeons. Survivors include a daughter and a sister.

○ **Stuart B. Gibson,** Jersey Shore, George Washington University School of Medicine, 1930; age 66; died April 23, 1971. He practiced medicine in Williamsport until his retirement. He is survived by his wife, a son, two daughters, a stepson, a stepdaughter, a brother, and a sister.

○ **Creed Cornelius Glass,** Myersdale; Jefferson Medical College, 1919; age 78; died April 20, 1971. He had operated the Hazel McGilvery Hospital in Myersdale for 30 years. He is survived by his wife and three children.

○ **Francis G. Harrison,** Philadelphia; University of Pennsylvania School of Medicine, 1913; age 80; died May 12, 1971. He is survived by a son, Francis G. Harrison, Jr., M.D., Philadelphia.

John Dwight Allen, Media; Jefferson Medical College, 1944; age 56; died April 9, 1971. He was a surgeon and medical director of E.I. Du Pc de Nemours. He was a member of t National Industrial Medical Socie the American College of Surgeons, a a fellow in the National College Surgeons. He is survived by his wife son, a daughter, two step children, a two brothers.

Philip J. Brings, Duquesne; Univ sity of Pittsburgh School of Medici 1928; age 68; died January 29, 197 Survivors are unknown.

Nora Marie McNerney Log Dubois; University of Pittsbur School of Medicine, 1921; age 8 died January 4, 1971. There is no formation regarding survivors.

Joseph D. Brown, Wyncote; J ferson School of Medicine, 1929; a 66; died April 19, 1971. He was on t staff at Jefferson, Chestnut Hill, a Roxborough Memorial Hospitals, a Woman's Medical College of Penns vania. Survivors are unknown.

Louis Vincent Miller, Elkins Par Ohio State University College of Me icine, 1959; age 44; died January 1971. There is no information garding survivors.

Ralph C. Kell, Berwyn; Jeffers Medical College, 1905; age 88; di April 24, 1971. He was a member the Dercum Neurological Society a the Pennsylvania Railroad Surgeo Assn. Survivors include his wife and daughter.

Caleb H. Smith, Wilmington, De University of Pennsylvania School Medicine, 1933; age 62; died April 2 1971. He practiced in Wilmington a in Bradford. Survivors include a son, daughter, and a brother.

Morris Smith, Bethlehem; Univers ty of Vermont College of Medicin 1925; age 72; died May 3, 1971. He survived by his wife, a son, thr sisters, and two brothers, Drs. Josep Smith and Jacob Smith, both of Bat Maine.

Armand Grant Sprecher, Ocea City, N.J.; University of Pennsylvan School of Medicine, 1926; age 6 died April 22, 1971. He practiced Philadelphia for 40 years. He is su vived by his wife, two daughters, and brother.

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General Practitioner— Needed to head new Medical Center (completion October 1) in picturesque Berks County, Pa. Located halfway between Allentown and Reading. Carefully designed for 2 doctors with 8 treatment rooms. Communities totaling 13,000 population offer tremendous potential. For prospectus and additional information, write Reverend J.R. Henrich, Mertztown Rt. 1, Pa. 19539.

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Physicians wanted for full or part-time medical services at State Mental Hospital in vicinity of Reading, Pennsylvania. Variety of duties available. Hours adjustable. Fringe benefits. Salary depends upon experience and time involved. Requirements Pennsylvania Medical license. Contact Personnel Officer, Wernersville State Hospital, Wernersville, Pennsylvania 19565.

Radiologist— Certified or eligible. Diagnosis, conventional therapy and isotope scans. To associate with Radiologist in 160-bed general hospital. Small college community; financial arrangements negotiable. Write Box 591, Pennsylvania Medicine, 20 Erford Rd., Lemoyne, Pa. 17043.

Wernersville (vicinity of Reading) Psychiatric Physician. 1200 bed State Mental Hospital serving 3 counties. Operates under unit system. Involves full clinical program and direct supervision of staff in acute and chronic areas. Requirements: Pennsylvania Medical license and 3 years residency or training program in psychiatry. Salary $19,664 to $21,672. Full range fringe benefits. Contact Personnel Officer, Wernersville State Hospital, Wernersville, Pa. 19565.

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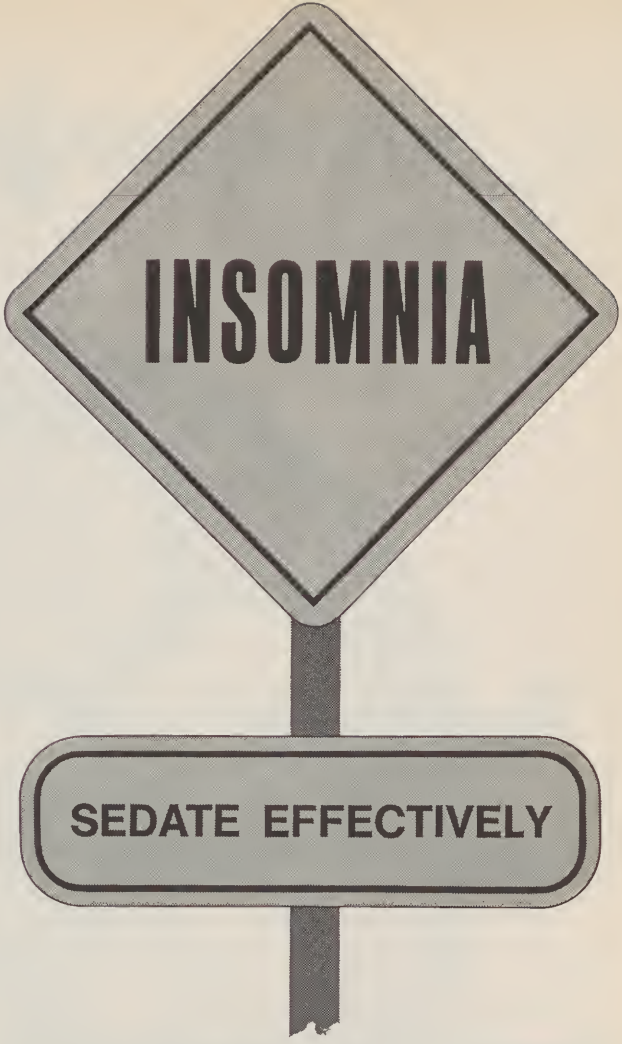

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Twenty-fourth Annual State Dinner

Tuesday Evening
October 5, 1971
Pittsburgh Hilton Hotel
Reception Dinner
Dancing and Entertainment

- Installation of George P. Rosemond, M.D., as the 122nd President of the Pennsylvania Medical Society
- Presentation of Past President's Medallion to William A. Limberger, M.D., 121st President
- Presentation of State Benjamin Rush Awards

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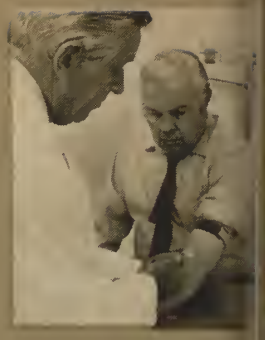
in stable adult diabetes, if diet alone fails...



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a biguanide... not a sulfonylurea

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lowers elevated blood sugar

How to prescribe DBI®-TD (phenformin HCl)

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Week 1 1 capsule with breakfast may be effective, or a second capsule may be given with the evening meal.

Week 2 Continue effective DBI-TD dosage. If necessary, add an additional capsule to the A.M. or P.M. dose.

Thereafter Continue effective DBI-TD dosage.

To transfer from sulfonylurea therapy to DBI-TD alone: The first week, withdraw sulfonylurea; start with DBI-TD as indicated in the chart.

To transfer from sulfonylurea therapy to combined therapy with DBI-TD: The first week, continue dosage of sulfonylurea; add DBI-TD as indicated in the chart. When effective regulation of diabetes is attained, sulfonylurea may be reduced and/or withdrawn.

Indications: Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary. **Contraindications:** Diabetes mellitus that can be regulated by diet alone; juvenile diabetes that is uncomplicated and well regulated on insulin; acute complications of diabetes (metabolic acidosis, coma, infection, gangrene); surgery; severe hepatic disease; renal disease with uremia; cardiovascular collapse, after disease states associated with hypoxemia. **Warning:** Use during pregnancy is to be avoided. Until adequate data on the effects of DBI on the human fetus are available, such use can be considered experimental. **Precautions: Starvation Ketosis,** which must be differentiated from "insulin lack" ketosis, and is characterized by ketonuria in spite of relatively normal blood and urine sugar, may result from excessive DBI therapy, excessive insulin reduction or insufficient carbohydrate intake. Adjustment of DBI-TD or insulin dosage, or supplying carbohydrates, alleviates this state. DO NOT GIVE INSULIN WITHOUT FIRST CHECKING BLOOD AND URINE SUGARS. **Lactic Acidosis:** DBI is not recommended in the presence of azotemia or in any clinical situation that predisposes to sustained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, it is recommended that periodic determinations of ketones in the blood and urine be made in diabetics previously stabilized on DBI, or DBI and insulin, who have become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH and the lactate-pyruvate ratio. DBI should be withdrawn and insulin, when required, and other corrective measures instituted immediately upon the appearance of any metabolic acidosis. **Hypoglycemia:** Although hypoglycemic reactions are rare when DBI is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with DBI. **Adverse Reactions:** Principally gastrointestinal, occurring more often at higher dosage levels; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, DBI should be immediately withdrawn. Although rare, urticaria and gastrointestinal symptoms following excessive alcohol intake have been reported. **Dosage:** 1 to 3 DBI-TD 50 mg. capsules daily. **FSN 6505-724-6331. Also Available:** DBI tablets 25 mg. **Supplied:** Bottles of 100 and 1000.

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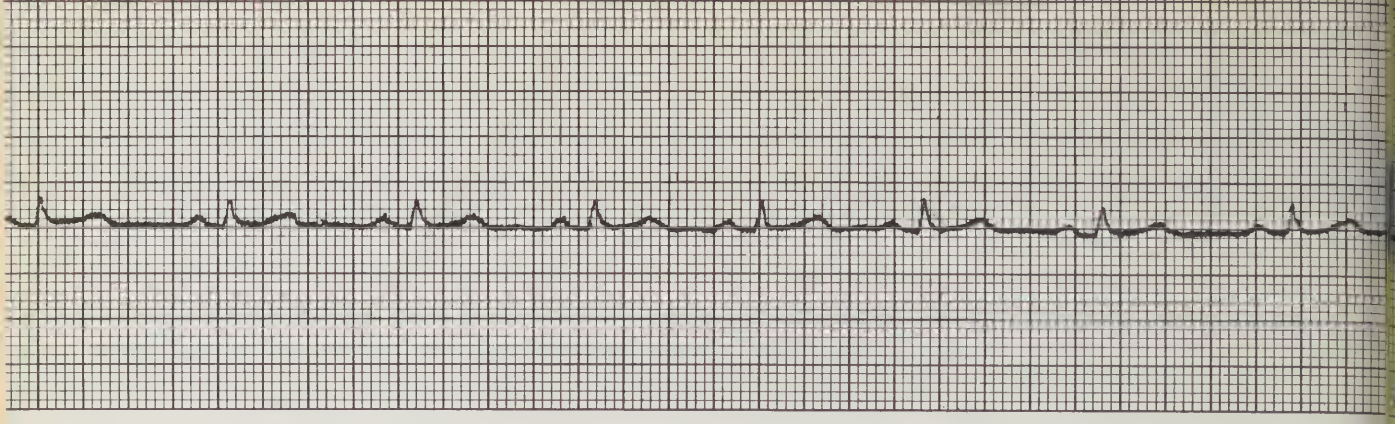

When disease is ruled out and psychic tension is implicated

Valium® (diazepam) 2-mg, 5-mg, 10-mg tablets helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Patients fell asleep quickly

Dalmane (flurazepam HCl) 30 mg reduced awake time—both before and after falling asleep - by fifty percent of pretreatment values in patients with insomnia.[1,2]

Two sleep laboratory studies recently confirmed findings of earlier studies of this type, namely, that Dalmane 30 mg was effective in patients who had trouble falling asleep, staying asleep or both. One 30-mg capsule of Dalmane usually induced sleep within 22 minutes, decreased the number of awakenings and the wake time after the onset of sleep, and provided 7 to 8 hours of sleep without need to repeat dosage during the night.

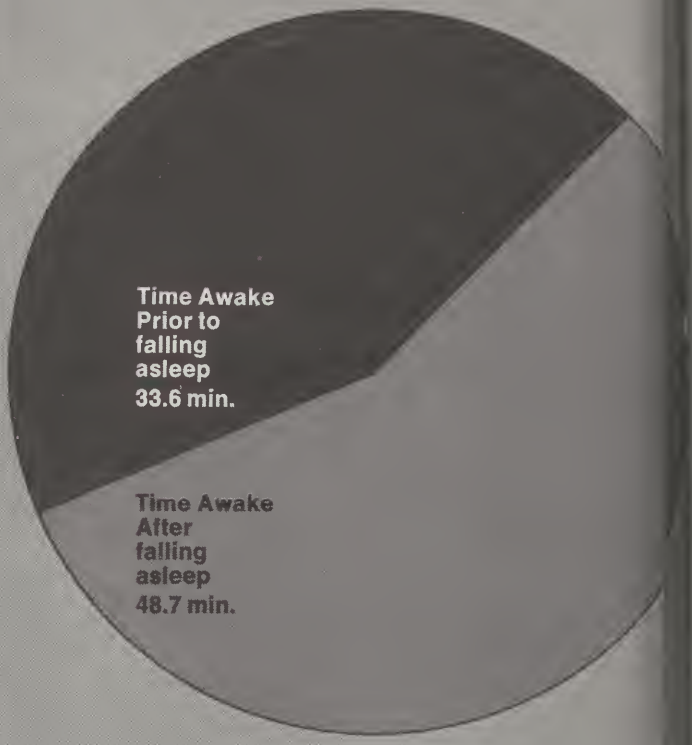
These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electro-encephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

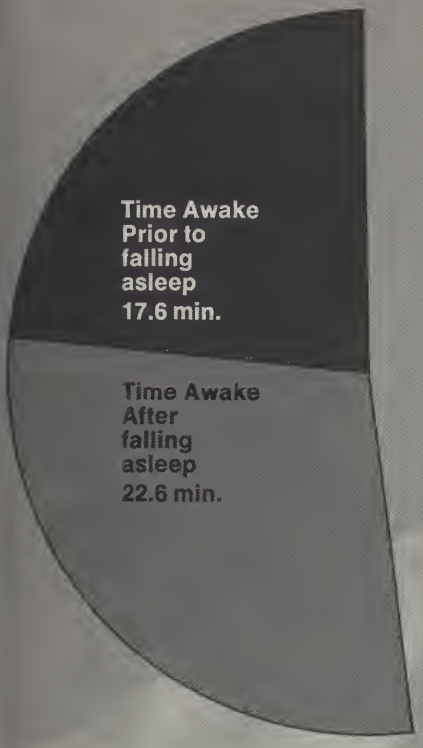
Before Dalmane (flurazepam HCl)



Measurements of sleep in the sleep laboratory are obtained with electroencephalographic, electro-oculographic and electromyographic recordings.

and slept through the night

On
Dalmane
(flurazepam HCl)



erage sleep laboratory measurements in cited studies

rameter	Before Dalmane	On Dalmane
me required to fall asleep	33.6 min.	17.6 min.
ke time after onset of sleep	48.7 min.	22.6 min.
mber of wakeful periods after onset of sleep	12.2	8.4
tal sleep time	420.0 min.	447.5 min.
tal sleep percent	88.6	94.5

linical effectiveness as roven in the sleep laboratory

Dalmane®
(flurazepam HCl)

ie 30-mg capsule h.s.—usual adult dosage.
ie 15-mg capsule h.s.—initial dosage for derly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Journal of the Pennsylvania Medical Society

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ygroton® chlorthalidone USP *Indications:* Hypertension and many types of edema involving retention of salt and water. *Contraindications:* ypersensitivity and most cases of severe renal or hepatic diseases. *Warnings:* With the administration of enteric-coated potassium supplements, which ould be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and rforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium pplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant women and rsing mothers since the drug crosses the placental barrier and appears in cord blood and since thiazides appear in breast milk. The drug may result fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of ildbearing age, balance benefits of drug against possible hazards to fetus. *Precautions:* Antihypertensive therapy with this drug should always be tiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. duce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic termination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte balance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and tassium supplements given, provided the patient does not have marked oliguria. Take special care in cirrhosis or severe ischemic heart disease and in tients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. *Adverse Reactions:* Nausea, gastric irritation, vomiting, orexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic potension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, ombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and ncreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of mpounds include: jaundice, xanthopsia, paresthesia, and photosensitization. *Average Dosage:* 50 or 100 mg. with breakfast daily or 100 mg. every other y. *How Supplied:* White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000. (B)46-230-G *For full details, please the complete prescribing information.*

EIGY Pharmaceuticals, Division of CIBA-GEIGY Corporation, Ardsley, New York 10502

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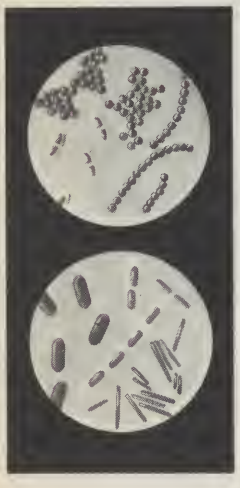
Facts about Loridine® I.M.
cephaloridine

Facts about activity

Loridine is indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed below.* It is active against the following organisms in vitro:



Beta-hemolytic and other streptococci (many strains of enterococci, e.g., *Streptococcus faecalis*, are relatively resistant)
Staphylococci, both coagulase-positive and coagulase-negative (some strains of staphylococci are resistant to cephaloridine)
Pneumococci
Gonococci
Hemophilus influenzae
Escherichia coli and other coliform bacteria
Klebsiella
Proteus mirabilis

Loridine also has demonstrated activity against *Treponema pallidum* in experimental syphilis studies in animals.

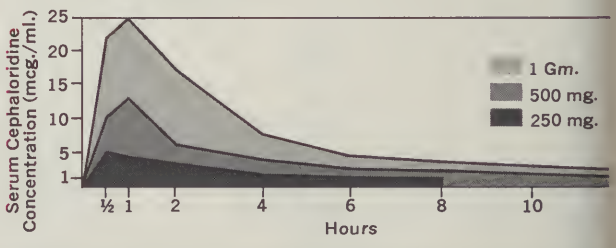
All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine. However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *H. influenzae*, *Pr. mirabilis*, *Esch. coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

*Loridine is indicated in the treatment of gonorrhea when penicillin is not considered the drug of choice.

Facts about dosage

In adults, most respiratory infections of moderate severity caused by susceptible organisms respond to Loridine in dosages ranging from 500 mg. to 1 Gm. every eight hours (1.5 to 3 Gm. daily). This use of lower dosages helps prevent drug accumulation. The more susceptible infections have been treated with 250 to 500 mg. every eight hours.



Mean Serum Cephaloridine Concentrations after I.M. Administration Single Doses (250 mg. to 1 Gm.) to Normal Human Volunteers (Six Eighteen Subjects per Group). (Modified from Currie, J. P.: Cephalo dine: Pharmacology and Toxicology, Postgrad. M. J., 43 [Supplement 22, 1967.)

Peak serum levels have been noted with Loridine withi one-half to one hour following I.M. injection. The mean peak serum levels obtained in normal subjects one hour after a 500-mg. I.M. dose ranged from 12 to 22 mcg. per ml. in separate studies. Administration every six to eight hours permits adequate concentrations to be maintained. In order to avoid excessive serum levels (which could possibly result in damage to the kidney tubules), recommended dosages should not be exceeded In adult patients without azotemia who have mildly reduced renal function manifested by slight to moderate transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the *maximum* recommended dosage is 1 Gm. every twelve hours during the period of reduced function.

Facts about administration

The following guidelines for therapy with Loridine are recommended.

Before Administration of Loridine

1. Establish susceptibility of the pathogen.
2. Determine patient's renal status; Loridine is contraindicated in azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status —urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit dosage to 4 Gm. daily for adults (100 mg. per Kg. for children—not to exceed adult dosage). Usual dosage range: 1 to 3 Gm. daily.

5. In patients with impaired renal function *before* treatment, reduce daily dosage and keep them under close observation for changes in function. In nonazotemic patients with mildly reduced renal function manifested by slight to moderate, transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the *maximum* recommended dosage (adults) is 1 Gm. every twelve hours during the period of reduced function.
6. In patients who develop impaired renal function or whose preexisting impairment becomes worse *during* treatment, discontinue therapy.

Since Loridine is relatively painless on I.M. injection, it is well accepted by patients.

There is clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins; therefore, Loridine should be used with great caution in patients with known penicillin allergy. Instances of patients who have had severe reactions to both drugs, including death from anaphylaxis, have been reported.

Loridine® I.M.
cephaloridine

Lilly

101666

(Please turn page for prescribing information.)

Loridine® I. M.
cephaloridine

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The p- sibility of this complication seems to₂ greater in seriously ill patients given m₂ than recommended doses. Acute tub- necrosis has been found in affected tients coming to autopsy. Rare cases f nausea and vomiting have occurred. F in association with intramuscular injec was noted in less than 3 percent of tients. In only one patient in a series f 623 was the route changed on this accou Phlebitis at the site of intravenous inj. tion has been rare.

Administration and Dosage: *Importar* Before administering Loridine, see pa- age insert for details on dilution.

Intramuscular Injection—Loridine, usually injected into a large muscle ma

The usual adult dosage for many inf tions of moderate severity is 500 mg. 1 Gm. three times a day at equally spac intervals. Milder and more susceptil infections have been treated with 250 500 mg. given two or three times a d More severe infections may be treat with 500 mg. to 1 Gm. four times a d A single 2-Gm. dose is recommended the treatment of acute gonorrhea. Ea syphilis may be treated with 500 mg. t Gm. daily for ten to fourteen days.

Although some clinical experience w high doses for life-threatening conditio has been reported, it has been shown th excessive dosages (above 4 Gm. dai may cause serious nephrotoxic reactio For this reason, Keflin® (sodium cepha thin, Lilly) may be preferred when dos larger than 4 Gm. daily are considered f life-threatening situations. If more than Gm. of cephaloridine is injected daily, t patient should be under close clinic observation for changes in renal functi or be hospitalized. In addition, reduc dosage should be employed in patien with known or suspected renal impairmer

In children, a daily total of 30 to 5 mg. per Kg. (15 to 25 mg. per pound) body weight, given in divided doses, h been found effective for mild to mode ately severe infections. A daily total of 1(mg. per Kg. (50 mg. per pound) of bo weight (not to exceed recommended adu doses) may be needed for very seve infections.

Intravenous Injection—In the presenc of extremely serious infections (such a bacteremia) or when any infection seem overwhelming, intravenous administratio may be indicated.

Total daily dosages are the same as wit intramuscular injection. For very suscep tible organisms, 500 mg. to 1.5 Gm. pe day may suffice; for less susceptibl organisms and for serious infections, 2 t 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cepha loridine, Lilly), 500 mg., 5-ml. size rubber-stoppered; 1 Gm., 10-ml. size rubber-stoppered. [08216

Additional information available to the professio on request.

Eli Lilly and Company
Indianapolis, Indiana 4620

101666

Noludar® 300
(methyprylon)

one capsule for the rest of the night

Before prescribing, please consult complete product information, a summary of which follows:

INDICATION: Relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

Each capsule contains 300 mg of methyprylon.

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RELEASES NICOTINIC ACID 2 WAYS
QUICKLY OR *GRADUALLY*

For Treatment of:

COLD FEET
LEG CRAMPS • TINNITUS
DISCOMFORT ON STANDING
WHEN ASSOCIATED WITH IMPAIRED PERIPHERAL CIRCULATION

ALSO PROVIDES CONCOMITANT ADMINISTRATION OF THE LISTED VITAMINS.

AVAILABLE IN THREE STRENGTHS

QUICK RELEASE		*GRADUAL RELEASE*
NOT TIMED	NOT TIMED	TIMED RELEASE 6 to 8 HOURS
LIPO-NICIN®/100mg.	**LIPO-NICIN®/250mg.**	**LIPO-NICIN®/300mg.**
Each blue tablet contains:	**Each yellow tablet contains:**	**Each capsule contains:**
Nicotinic Acid .....100 mg.	Nicotinic Acid .....250 mg.	Nicotinic Acid .....300 mg.
Niacinamide ..... 75 mg.	Niacinamide ..... 75 mg.	Vitamin C (Ascorbic Acid).150 mg.
Ascorbic Acid .....150 mg.	Ascorbic Acid .....150 mg.	Vita. B1 (Thiamine HCl).. 25 mg.
Thiamine HCl (B-1) .. 25 mg.	Thiamine HCl (B-1) .. 25 mg.	Vitamin B2 (Riboflavin) .. 2 mg.
Riboflavin (B-2) ..... 2 mg.	Riboflavin (B-2) ..... 2 mg.	Pyridoxine HCl (B-6) .... 10 mg.
Pyridoxine HCl (B-6).. 10 mg.	Pyridoxine HCl (B-6).. 10 mg.	**DOSE:** 1 to 2 capsules daily.
DOSE: 1 to 5 tablets daily.	**DOSE:** 1 to 3 tablets daily.	**AVAILABLE:** Bottle of 100, 1000.
AVAILABLE: Bottles of 100, 500, 1000.	**AVAILABLE:** Bottles of 100, 500, 1000.	*In a special base so prepared that the active ingredients are released over a period of 6 to 8 hours.*

SIDE EFFECTS: Flushing with heat and itching, in some cases followed by sweating, nausea and abdominal cramps. This reaction is usually transient. Nausea caused by high acidity can be relieved by non-absorbable antacid. **REFERENCES:** 1. *Parsons, W.B., Jr. — Interview Med. Trib. Nov. 28-29, 1964.* 2. *Cohen, D., JAMA, Aug. 6, 1960, Vol. 173, No. 14, P. 1563.*

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BROWN **The BROWN PHARMACEUTICAL COMPANY, INC.,**
2500 West 6th Street, Los Angeles, California 90057

REFER TO PDR

At last-an answer to your malpractice protection anxiety.

An insurance program sponsored and supported by the PMS.

The Pennsylvania Medical Society has been increasingly concerned about the problems faced by its members in securing and retaining professional liability insurance. There has been a growing tendency for insurance carriers to arbitrarily cancel, or not renew, professional liability insurance contracts for reasons entirely beyond the physician's control.

The obvious answer had to be a program, sponsored by the Pennsylvania Medical Society, designed to provide its members with *long term* coverage, adequate limits, at the best possible cost, in addition to giving the Society an opportunity to participate in the policy-making and administration of the program.

Such a program, more progressive and comprehensive than any that has been made available to any medical group, now exists. It is being underwritten by the Argonaut Insurance Company, a well established, "A+AAAA" rated casualty insurance carrier with assets in excess of $180,000,000 and considerable experience in the medical liability field. The exclusive, full-time administrator of the program is Parker & Co. Inc. of Pennsylvania, one of the country's leading insurance brokerage firms.

In review, the major points of the program are:

1. The Pennsylvania Medical Society has entered into an agreement with the Argonaut Insurance Company to administer the program through Parker & Co., Inc. of Pennsylvania.
2. The Argonaut Insurance Company will be bound to make this program available for a *minimum of five years. No* other carrier has offered such an agreement.
3. The Society participates through a Professional Liability Insurance Commission consisting of twelve members. The Commission will be the ultimate authority in appeals stemming from disputes between member insureds and will work in close conjunction with the local district committees.
4. No member's application will be declined except by the *joint decision* of the PMS Commission and the Argonaut Insurance Company.
5. Full liability coverage of $100,000 for each claim with an annual aggregate limit of $300,000 with excess limits up to $1,000,000 available. Coverage *is* available for interns, residents and physicians' and surgeons' assistants.
6. Rates are competitive with other major writers of professional liability insurance in Pennsylvania.
7. There is no requirement that a member purchase ancillary insurance coverages (homeowners, auto, etc.) in order to participate.

This program offers PMS members a unique opportunity to stabilize their professional liability insurance coverage on a long term basis. However, a broad based, high degree of membership involvement is essential to make this program a success. Please fill out the coupon indicating your interest in participating in the PMS endorsed program when your present coverage expires.

Argonaut Insurance Companies

Mail to:
Parker & Co., Inc. of Pennsylvania
1616 Walnut Street, Philadelphia, Pennsylvania 19103
Attention: Mr. A. John Smither, Vice President

Name_____

Office Address_____

Telephone No. _____

Medical Specialty_____

Date your professional liability insurance expires _____

Present Carrier _____

I am interested in participating in the PMS Professional Liability Insurance Program. Please send me an application. ☐

BLUE SHIELD RATE INCREASE HEARING HELD State Insurance Commissioner Herbert S. Denenberg held a day-long hearing late in August on a Blue Shield request for an increase in rates for its 65-Special Contract and used the forum to continue his pressure for health care delivery controls and greater consumer representation on the Blue Shield Board. Blue Shield is asking that the monthly rate for its medicare (Part B) supplemental insurance be increased by $.75 from the present $2.25. The PMS, through the chairman of its Council on Medical Service, Robert P. Dutlinger, M.D., testified in support of the rate increase. The Insurance Commissioner asked him only a few mild questions. The general tone of the hearings was described in a release from the Office of the Insurance Commissioner. It read in part: "In typical Herbert S. Denenberg style, the Insurance Commissioner refused to limit himself to the dollar issues at hand because he said 'to do so would result in an automatic rate increase. We've got to look at the broader issues... The time for automatic rate increases is over.'" No decision on the rate increase request was announced but apparently the national wage-price freeze prevents any immediate rate adjustments.

HEW COMMISSION TO PROBE MALPRACTICE SITUATION HEW Secretary Elliott L. Richardson has announced the creation of a commission to probe the entire range of problems associated with medical malpractice claims against health care providers. The Secretary's Commission on Medical Malpractice will be headed by Pittsburgh attorney Wendell Freeland. In his announcement, Secretary Richardson called the malpractice situation "one of the nation's most vexing health problems." Eli P. Bernzweig, HEW specialist in malpractice, has been named executive director of the commission's staff.

GROUP MALPRACTICE CONCEPT SPREADS With an approach patterned after the State Society-endorsed malpractice insurance program, the AMA and CNA Insurance have announced a plan for physicians in states that do not already have such an arrangement. Like the PMS program with Parker & Company, Inc., and Argonaut Insurance Company, the AMA plan provides for active involvement of the medical profession in underwriting decisions and protection against unexpected cancellation of coverage.

HMO OPERATIONAL AT TEMPLE Governor Shapp has signed a one-year $2.8 million contract instituting a health maintenance organization administered by an arm of Temple University to provide total health care for 12,000 North Philadelphians of the West Nicetown-Tioga section. The state contract provides prepayment for area residents on state Medical Assistance. Others living in the area are being invited to participate at rates comparable to privately operated health insurance programs. PMS President William A. Limberger, M.D., comments on the HMO concept starting on page 15 of this issue.

SUPPLEMENTAL CALL TO THE ANNUAL SESSION Included in elections at the Annual Business Session Wednesday morning, October 6, 1971, at the Pittsburgh Hilton will be one member of the Judicial Council to serve for a term of five years to succeed Lewis T. Buckman, M.D., Luzerne County, who is eligible to succeed himself. As directed by Article IX, Section 5, of the Constitution, the Board of Trustees nominates the following members for the vacancy on the Judicial Council: Lewis T. Buckman, M.D., Luzerne; Charles A. Bikle, M.D., Franklin; and Thomas W. McCreary, Sr., M.D., Beaver.

HOSPITALS END CONTRACTS WITH BLUE CROSS J. C. Blair Memorial Hospital, Huntingdon, has announced it will terminate its contract with Blue Cross October 1. The hospital joins three others, Altoona and Mercy Hospitals in Altoona which ended contracts July 1, and Tyrone Hospital, Tyrone, which terminated August 1. The hospitals claimed $1 million losses in the past year and said Blue Cross reimburses for full costs but not for full charges. Hospital spokesmen said full charge reimbursement is necessary to offset losses from medicare and medicaid payments.

NEW SVRMP DIRECTOR SOUGHT Richard B. McKenzie has resigned as director of the Susquehanna Valley Regional Medical Program, effective in mid-August, and a Search Committee has been appointed to interview applicants-- limited to medical doctors-- for the position. The chairman of the Search Committee is John H. Harris, Sr., M.D., and the members include the new chairman of the Regional Advisory Group, George C. Williams, Esq. Others are Raymond C. Grandon, M.D.; David S. Masland, M.D.; and George A. Rowland, M.D.

GOVERNOR SIGNS Governor Milton J. Shapp has signed a bill requiring that the services of podiatrists and chiropractors be covered equally with those of doctors of medicine and osteopathy under insurance policies issued in the Commonwealth. The law, Public Act 78 of 1971, does not include Blue Shield.

HEALTH ADVISORY BOARD ACTS The Pennsylvania Department of Health Advisory Board at its recent meeting adopted new regulations designed to curb hepatitis. Blood for transfusions is not to be accepted from anyone who has ever had viral hepatitis or who has had close contact within the previous six months with a hepatitis victim... The importation and sale of live turtles have been prohibited except by permit which will be issued only upon laboratory proof that the creatures are free of salmonella. A cautionary warning must be posted at every display of turtles for retail sale... All school districts have been directed to do selective testing for tuberculosis on an annual or triennial basis depending on the individual school's reactor rates... Blood specimens for alcohol content now must be taken from the bodies of an operator of a motor vehicle or any pedestrian over sixteen years of age who dies within four hours folflowing a motor vehicle accident... Lead poisoning has been made a reportable disease in the Commonwealth.

Board approves Medical Practice Act draft

The PMS Board of Trustees and Councilors at its August meeting approved a draft for a new medical practice act, and authorized that ways be sought to have it introduced into the Legislature.

Prepared by a committee of the Society chaired by William J. Kelly, M.D., Pittsburgh, trustee and councilor of the Tenth District, the Medical Practice Act of 1971 replaces all previous public laws relating to medical licensure and, if adopted, is expected to give Pennsylvania preeminence among the states in legislation relating to medical practice.

Among the innovations in the proposal is the addition to the Board of Medical Education and Licensure of a member who shall be a dean of one of the state's medical colleges, and the addition of a member to represent the public.

The proposal also permits the new Board of Medical Education and Licensure control the organization of and to regulate various paramedical specialties, including physicians assistants. A new section spells out reasons for the board to refuse to grant licenses to practice and to revoke licenses. A complete explanation of the proposal, known as the "Kelly Committee" draft, will appear in PENNSYLVANIA MEDICINE in the near future.

Further drug regulations issued

The Bureau of Narcotics and Dangerous Drugs (BNDD) has issued further regulations of concern to physicians and pharmacists.

All amphetamines and amphetamine combinations with the exception of four became Schedule II items under the Controlled Substances Act of 1970 on August 6. Of the four, three became Schedule II items on August 23, meaning that all amphetamines and combinations which now have the C Rx symbol are in Schedule II, with the exception of Eskatrol (® Smith, Kline and French). This means they require a written prescription and are not renewable. See the May 1971 issue of PENNSYLVANIA MEDICINE for details of the Controlled Substances Act of 1970.

Registration of all prescribers of medication has not yet been completed, and the final date on which the BNDD registration numbers must be used has been extended to October 1, 1971. However, the agency requires that any prescription for a controlled substance contain either the BNDD registration number of the prescriber, or a statement which says, "Federal registration applied for on (date)."

M.D. aid requested

Physicians in Armstrong, Carbon, Lawrence, and Northumberland counties, and in Philadelphia and Pittsburgh may be requested to verify costs and medical service use reported by household informants in a University of Chicago survey for the Center of Health Administration Studies and the National Opinion Research Center.

The American Medical Association has requested the cooperation of physicians in filling out and returning the questionnaires in order to insure the validity of the study which will be used as a standard source for the health field.

Avis discount plan offered PMS members

Avis Rent A Car has extended the Avis Cash Commercial Corporate Discount Plan to all Pennsylvania Medical Society members.

Within the United States, a 20 percent discount will be offered on automobile rentals and a 10 percent discount on truck rentals, while a 10 percent discount will apply outside the country.

Members may obtain the discount by showing their PMS membership cards.

Although this is a cash discount plan, Avis-honored charge cards such as Bank Americard, American Express, and major airline travel cards may also be used.

Your PMS membership card must be presented in order to qualify for the discount.

DOCTORS OF MEDICINE AND OSTEOPATHY in the Commonwealth have enjoyed a day of joint medical education during the past two years and are scheduled to repeat the performance on April 15, 1972, when the subject of the seminar will be gastroenterology. Among those making such a meeting possible are Merck, Sharp and Dohme Co., West Point, Pa. Shown above are Raymond C. Grandon, M.D., left, Harrisburg, president of the Dauphin County Medical Society and secretary of PMS, and Leonard Zimet, executive director of the Pennsylvania Osteopathic and Medical Association, receiving a check to support the project from Andrew J. Zonay, Jr., professional representative of the company.

GEORGE G. MARTZ, Ringgold, and his wife hold certificates presented to them on the occasion of his 100th birthday by Charles Brohm, M.D. of Hawthorn and Punxsutawney on behalf of the Pennsylvania Medical Society. Mrs. Martz is 102. The couple have raised six children since their marriage almost 79 years ago and still reside on the farm from which he made a living for nearly a century.

JCAH adopts new standards for hospital accreditation

The Joint Commission on Accreditation of Hospitals (JCAH) has adopted new accreditation standards effective recently.

They contain a preamble which states that a patient has the right to know what is being done to him, the reasons for it, and who is responsible for his case.

John H. Porterfield III, M.D., director of JCAH, says that the new standards are explicit about the patient's right to physical privacy and his right not to be used for teaching or research purposes except with his consent. Care cannot be refused because of race, creed, color, national origin, or because of the source of payment of his bill.

Under the new standards, information will be accepted from the general public that could influence the accreditation survey. Dr. Porterfield predicts that the percentage of hospitals to be denied accreditation will increase slightly, as will the percentage of hospitals that will not receive the maximum two-year accreditation.

Health program for migrant workers under way

The Pennsylvania Department of Health has launched a health program for migrant farm workers to operate from July to December. It covers approximately 7,500 laborers and their dependents in twenty-one counties.

Funded by a U.S. Public Health Service grant, it provides the services of physicians, nurses, and dentists; laboratory, diagnostic, and emergency facilities; immunization and drugs.

State Health Secretary J. Finton Speller, M.D., announced the new service this year of a mobile clinic for eye examinations previously screened by the Pennsylvania Association for the Blind. It is being sponsored by the association and staffed by a Spanish-speaking ophthalmologist lent by the Wills Eye Hospital, Philadelphia.

Pharmacies, laboratories, and diagnostic facilities at the Geisinger Medical Center, Danville; the Annie M. Warner Hospital, Gettysburg; and the Tri-Valley Medical Center, Valley View, are providing clinical service. In counties without clinics, local medical personnel and facilities, as well as a mobile dental unit, are being made available by the Pennsylvania Department of Health and the Pennsylvania Dental Services Corporation. Religious, civic, and government agencies all are donating services.

Western Pa. RMP receives grant

A $1.3 million grant has been awarded to the Western Pennsylvania Regional Medical Program by the U.S. Department of Health, Education, and Welfare to support eight projects.

Increased autonomy has resulted from a lessening of federal supervision, with governmental review being cut to once every three years instead of annually, technical review being placed in local hands, and limited spending being authorized for new projects without the necessity of federal review.

Budget limitations have resulted in the loss of a project to train home nursing personnel. Library services and continuing education programs will no longer be free, and a tuition charge must be initiated to continue the coronary nurses training program. However, the award makes possible three new projects: assistance for a sickle cell anemia detection program, a diabetes diagnosis and treatment study, and a lung disease detection and treatment project in Cameron, Clearfield, Elk, and Jefferson counties.

Coronary care ambulance a first in Philadelphia

The first mobile emergency coronary care ambulance in Philadelphia has been devised by Pennsylvania Hospital through a $50,000 United Fund grant.

Component parts include a portable and fixed oxygen supply, a defibrillator, an electrocardiograph machine, a portable suction device, and an artificial breathing apparatus. It is staffed by a doctor, a nurse, and a driver trained to render assistance. Emergency care will be given on the spot and the patient will be transported directly to the hospital's new coronary care unit.

This specially equipped and staffed unit is expected to tackle the problem of over 300,000 heart attack deaths in the United States which occur yearly before the patient can receive medical attention.

Editor named to committee

David A. Smith, M.D., Harrisburg, medical editor of PENNSYLVANIA MEDICINE, has been named a member of the advisory committee of the State Medical Journal Advertising Bureau of Oak Park, Ill.

College offers definition of 'preventive medicine'

The Board of Regents of the American College of Preventive Medicine (ACPM) at its recent meeting adopted an official definition of the term "preventive medicine."

"*Preventive medicine* is that branch of medicine which has primary interest in preventing physical, mental, and emotional disease and injury in contrast to treating the sick and injured. Secondarily, it is concerned with slowing the progress of disease and conserving maximal function."

Announcing the definition at the joint meeting of the American College of Preventive Medicine and the AMA Section on Preventive Medicine, ACPM President William P. Richardson, M.D., Chapel Hill, N.C., said, "In an era when preventive medicine is being given emphasis greater than ever, a clear understanding of the term is essential for the medical profession, government, and the public."

He cited the remarks of President Nixon, speaking to the AMA House of Delegates in Atlantic City June 22nd. The president urged greater emphasis on preventive medicine. He said, "As we look at American Medicine, we... see a need to place more emphasis on primary care, on preventive medicine, and on outpatient treatment."

Identifying drug abuse as public enemy number one, the President added, "The best way to end drug abuse is to prevent drug abuse. America's doctors are the indisputable front line soldiers for success in this all important battle."

The president of the American College of Preventive Medicine, Dr. William P. Richardson, Chapel Hill, N.C., said of the endorsement of the preventive approach: "We join President Nixon in urging the inclusion of preventive programs as an integral part of health care services. The preventive approach is essential for dealing effectively and economically with today's burgeoning health problems including the drug abuse dilemma. I urge the College membership to assist the President in his campaign against drug addiction."

Dean Sigel chairman

Bernard Sigel, M.D., Philadelphia, dean of the Medical College of Pennsylvania, has been elected chairman of a committee recently reactivated by the deans of the seven Pennsylvania medical schools to study the development of health care delivery services, state funding, and continuing education.

Dr. Sigel, who will serve a two-year term, will act as liaison between the medical deans and the Pennsylvania Medical Society, the Pennsylvania Department of Education, and other agencies related to medical education and delivery.

Booklet available

A booklet entitled "Why the Massachusetts Medical Society Opposes Chiropractic" has received widespread attention recently. It is available to physicians free of charge by writing to the Massachusetts Medical Society, Dept. 4, 22 The Fenway, Boston, Mass. 02215.

Occupational health warning issued

A warning that up to 250,000 workers in Philadelphia are being exposed to industrial health hazards has come from Norman Williams, M.D., Philadelphia's occupational health and pollution advisor, who is also a professor of community health and preventive medicine at Jefferson Medical College.

Gulf Oil Corporation has provided a $5,000 unrestricted grant for continuation of the college's occupational health education program.

Dr. Williams said that although many of the larger commercial enterprises in Philadelphia maintain adequate health services for their employees, the smaller companies do not. Citing such problems as carbon monoxide poisoning of automobile mechanics, cancer from asbestos dust in pipe fitters, deafness in pneumatic drill operators, and dermititus from chemicals and radiation in factory workers, he called for a city-wide occupational program which would:

- Protect each worker from hazards detectable in his environment;
- Coordinate the efforts of all agencies, public and private, for controlling in-plant and environmental pollution;
- Provide specially designed, periodic medical examinations of individual employees to prevent the development of illness and treat existing illness;
- Educate both employees and management in the prevention of occupational disease.

PMS roster available

The 1971-72 Roster of Pennsylvania Medical Society members is now available. Listings include: county society officers, alphabetical listing within each county society, state-wide alphabetical listing, and specialty society information. Society members are entitled to a complimentary copy. Copies are available to non-members and organizations from Society Headquarters for $10.00

Health conference called

The annual Fall Health Conference of the Pennsylvania Health Conference Committee will be held September 12-14 at the Penn Harris Motor Inn. The topic will be, "The Health Scene: 1985," presented through an electronic game called STAPOL operated by the Institute of the Future, Middletown, Conn. For further details contact William E. Graffius, conference chairman, Pennsylvania Health Conference Committee, 2 Clemson Dr., Camp Hill, Pa. 17011.

Family practice tests slated

The American Board of Family Practice has announced that its next examination for certification will be given over a two-day period on April 29-30, 1972, in various centers throughout the United States.

The deadline for applications is February 1, 1972. For information write: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

A Hospital Experience for Premeds

LESTER KIEFT
Lewisburg

There is general agreement that experiences provided by work performed in medical or para-medical areas during summer months often sharpens the motivations of premedical students to become medical practitioners and can, depending on individual circumstances, be of aid to admissions committees in evaluating the interest of the student in medicine. Building on the value of the educational "fall-out" derived from a summer practicum, we have sought to design a program for premedical students which involves one month of "practice" in a similar "medical work environment" under the direction of one or more physicians.

Bucknell University, Lewisburg, like many colleges and universities, is experimenting with its academic calendar. Two years ago the faculty approved what is commonly known as the 4-1-4 plan. The month of January is set aside for special projects which normally would not be possible during the regular semester. The students can arrange their own program or can register for one of the many projects sponsored by faculty members. The "January Program" is not required for graduation, and no academic credit is awarded. There are only two pre-requisites: high motivation and interest in a subject or field.

Premedical students have the opportunity during January to take part in what we call a Medical Training Program. However, the student must take the initiative. He is required to contact his family physician and the administrator of a hospital near his home, explaining that he is a premedical student interested in learning more about a career in medicine and that he has the month of January to do a special project under the guidance of physicians or other professionals they may designate. The Premedical Committee follows this initial contact by writing to the hospital administrator and physician and explaining the goals of the January Program. The committee also sends several student reports of their January experience so that the sponsors have a better idea of what might be accomplished.

Though involvement of the students varied considerably, all students agreed on the worth of the "field" experience. They spent time in various sections of the hospital— admissions, clinics, emergency room, laboratory, pathology, physical therapy, records, x-ray, etc. They accompanied the physician on his hospital rounds and witnessed a number of operations. In a few cases, the student was invited to the physician's office and sat in on the office calls. At most hospitals they were invited to attend the staff meetings and the medical conference, where the doctors present and discuss the unusual cases of that day.

During January, 1970, thirteen premedical students were involved in the program. Four of the students worked at the Evangelical Hospital, Lewisburg. So great was the enthusiasm of these four students in their report to the Premedical Club, that fifty students enrolled in the program for 1971. These students worked at thirty-eight hospitals in Connecticut, Maryland, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, Vermont and Washington, D.C. Only one student was assigned to each hospital with the exception of our two local institutions, the Evangelical Hospital and the Geisinger Medical Center, which each took five students. A number of physicians, who did their undergraduate work at Bucknell, have indicated an interest and a desire to participate in the program by sponsoring one of the premedical students in their area.

At the conclusion of the program the student prepares a report on his activities and evaluates the positive and negative aspects of his individual project. Let me share just four of the many interesting comments taken from the reports: "Often while performing an operation, the surgeon would explain what he was doing and what we should be looking for." "I never realized what a major role the laboratory plays in the diagnostic process." "The most interesting experience was the opportunity to accompany doctors on their hospital rounds. On interesting cases, the doctor would relate the patient's case history and explain the symptoms of the patient and how they differed from what would be found under normal conditions." "The program was very worthwhile. It allowed me to see beyond the public-conceived image of the physician into the reality of the trials, successes, disappointments, and hard work that are routine to most physicians. Fortified by this insight I am much better prepared to make an intelligent decision on the final choice of medicine as a profession." The students returned to Bucknell at the end of the month with renewed vigor and a desire to reach their goal. Their discussions with the doctors gave them a better idea of what elective courses they should take and why they want to take them.

I would recommend a January Program in a hospital to all premedical students. It will be an exciting and challenging experience, for this is an excellent "early" opportunity to talk with physicians active in various professional fields and thus obtain a clearer picture of the medical profession. The January Project can also be of tremendous help in aiding the Premedical Committee to evaluate the motivation and interest of the premedical student in medicine and thus, indirectly help the admissions committees of the medical schools.

Bucknell University's program offers on-the-job training for students—see a related article on page 55.

Some Thoughts on the PMS Medical Care Foundation

William A. Limberger, M.D., President of the Pennsylvania Medical Society, spoke during the dedication ceremonies of the Mon Valley Community Health Center near Monessen, in a non-urban section of the southwestern part of the Commonwealth. The week-long dedication had as its theme "Toward the Efficient Delivery of Comprehensive Health and Welfare Services: A Challenge for Non-Urban America." Dr. Limberger, who has traveled extensively throughout the state during his term as PMS President, contributed the thoughts on these pages.

Two House bills and a Senate bill to assist in the establishment of health maintenance organizations have been introduced in Congress by the Administration. The stated goal of each of the three bills: To help solve some of our national health care delivery and financing problems. The proposers of the three bills feel that more competition is needed in the health field and that the development of group practices and other types of prepayment programs will save money for the public through the better utilization of health care manpower and facilities.

The name "Health Maintenance Organization." (HMO) in itself deserves an explanation. The very name engenders support because who could be opposed to an organization designed to maintain health? As we weigh the available facts and opinions, you individually will draw your own conclusions on how well the ideals expressed in the name can be translated into public benefits.

Basically, it is the goal of a health maintenance organization to provide a range of benefits for members of the public enrolled in its plan in exchange for a fixed amount of premium dollars for health and medical care insurance.

In its most commonly understood function, a given family enrolled in a health maintenance organization would pay a fixed premium and in turn would receive any health and medical services they require without additional cost. The name "Health Maintenance Organization" therefore, comes from the understood fact that those who provide the health and medical services have a financial incentive to keep the enrolled members of the public as healthy as possible, that is, to provide care to enrolled members in a manner designed to avoid costly hospitalization and medical procedures. This, the proponents say, places the emphasis on the prevention of disease among the organization's subscribers because the organization would suffer financially if and when any of its enrollees suffer diseases that require a major amount of services.

The types of care generally provided involve, as a minimum: emergency care, in-patient hospital and physician care, ambulatory physician care, and preventive

medical services such as immunizations and screening tests.

Variations Are Many

There are many variations to this common concept of a health and maintenance organization. For example, various insurance premium structures are available to provide other than complete prepayment of all covered services. Some would allow for a nominal fixed per-visit amount in addition to the prepayment dollars and other variations would offer lower premiums for a reduced range of services.

The services of physicians would be provided by those who are employees or partners of the health maintenance organization or by those who work under other contractural arrangements with the organization on the basis of a fixed amount for a fixed number of patients for specified services. With such a group, the individual physician members might be reimbursed on a fee-for-service or other basis, but if the dollars paid out would exceed the income from premium dollars, the physicians agreeing to provide the covered services would have to do so for a reduced or even no reimbursement.

The HMO must present proof of financial responsibility and of its capability to provide comprehensive health care services efficiently, effectively and economically.

The legislation specifies that prompt, appropriate, and quality service must be available to the enrolled members of the public. At least once a year, an open enrollment period must be held at which time individuals are to be accepted in the order in which they apply up to the limits of the capacity of the HMO with at least half of the enrollees under the age of 65. The legislation specifies that the organizations must keep adequate records and must report, as required, to the Secretary of Health, Education and Welfare.

Under the provisions of the three bills, planning grants are available to assist potential sponsors of the health maintenance organizations, both in the private and public sectors. Furthermore, direct federal grants and loans would be made to help offset the special risks and costs of locating health maintenance organizations where physicians are in short supply. Federal loan guarantees would be available for health maintenance organization sponsors to obtain private loans in the first year of the contract for the construction of physical quarters and to help sustain operating deficits until the enrollment is high enough to give the facility a chance to pay its own way.

The Administration expects that if these bills are approved, by 1986 ninety percent of the entire population of the nation will have an HMO available to it as an alternative to the currentlly available means of receiving health care and that approximately twenty-five percent of the population will have elected to enroll in a health maintenance organization.

What are Proponent's views of HMOs?

1. They claim that health maintenance organizations — as a result of their contractural responsibilities — have wide latitude to make their own professional decisions such as establishing priorities for patient care and assuring the adequacy and quality of care provided.

2. Proponents say HMO's, contracting to provide care for a defined population, could plan and justify their present and future needs for facilities, equipment, professional manpower, and capital and operating costs.

3. They feel that contracturally stipulated performance reporting by a health maintence organization and competition could minimize the need for outside interference in the internal affairs of the health maintenance organization.

4. They assert that a health maintenance organization could assure the delivery of medical services more efficiently and effectively than fee-for-service provides — at a predetermined cost to government and to the consumer.

5. They cite the economic incentives to utilize modern business techniques and new types of health manpower, to avoid duplicating services, and to utilize less expensive care appropriate and adequate to a patient's needs.

6. They note that groups of physicians receiving capitation payments, based on peer decisions, could remunerate their physicians on any basis.

7. Backers say a health maintenance organization could emphasize preventive services and ambulatory care, assuring continuity, accessibility, and availability of patient care.

8. Supporters feel that recipients of public programs could be cared for as regular patients both administratively and professionally and that this could help some of the problems of financing medical care without imposing a national health system on the nation.

9. They note that the administration, through HMOs, desires to place the entire responsibility for peer review, peer review costs, and accessibility to medical care in the hands of the medical profession.

Opponents' Views

The opponents of such plans maintain that:

1. Multiple health maintenance organizations competing for enrollees in a given locality could create formidable problems for government and the profession in assuring the adequacy and quality of service.

2. Some fear that profit-making organizations in the health care industry could produce a crop of health maintenance organizations out for a "quick buck" with great harm to the patient by postponing services that are needed.

3. They worry that fixed contract prices, with the necessity of fiscal soundness in a highly competitive market, could result in "cutting of corners" to the disadvantage of patients.

4. Opponents say the increasing necessity for peer review activities by physicians to insure quality of care can only result in more responsibility and duties on an already overextended physician supply. Surveillance of quality care will require professional record review, survey, and continuing evaluation of performance.

5. They claim that many factors may result in costs exceeding the contractural stipulated rate with very little possibility of ever building a surplus for contingencies.

6. Foes say health maintenance organizations will, in all probability, attract a disproportinate enrollment of poor risks with resultant fiscal problems.

7. They feel that financial hardships are likely to be created for enrollees of relatively small and independent health maintenance organizations with limited access to

highly specialized professions and facilities. Use of services outside the health maintenance organization would be barred except for an emergency or if contracts specifically provide for such services.

8. Opponents say some physicians and the more sophisticated institutions geared to deal with specialized and complicated medical conditions, with resultant higher costs, might be unable to participate in the health maintenance organization because reimbursement would not be sufficient under some government-specified conditions.

9. The skeptics feel that techniques to evaluate performance would be difficult to apply to the forseeable diverse settings in which health maintenance organizations would be operating.

10. They state that prepaid group practice programs (and this could apply equally to other types of practices qualifying as health maintenance organizations) have frequently resulted in impersonal care, lengthy waits for appointments, unhappy subscribers, and an impression of deterioration in the quality of medical care provided.

11. They say the lack of mobility of the "captor" patient, i.e. freedom to select a physician outside the health maintenance organization at a time when care is needed but not available, would be detrimental to the provision of good quality medical care.

12. It is claimed that there is no guarantee that the formation of health maintenance organizations would result in greater accessibility and availability of medical care — two of the major stated justifications for the creation of health maintenance organizations.

13. Lewis J. Segodelli, associate director of Group Health Organizations of America, says that in organizing a health maintenance organization, the government should be prepared to spend two years and to lose $750,000 on each one. With the proposal that 100 such groups be organized, this means a loss of $75,000,000.

Pennsylvania Medical Care Foundation

With increasing political and government interest in the quality of medical care, peer review functions, and health maintenance organizations, the House of Delegates of the Pennsylvania Medical Society in October, 1970, approved in principle the formation of a Pennsylvania medical care foundation and directed that a specific one be developed for House consideration in October of this year. Such work is well under-way, a constitution and bylaws have been prepared, and the Pennsylvania Medical Society Board of Trustees has directed that articles of incorporation be filed.

The purpose of this non-profit foundation is as follows:

1. To promote, develop, and encourage the distribution of medical services by corporate members to the people of Pennsylvania at a cost that meets the best interest of both patient and physician.

2. To preserve for its members, the medical profession at large, and the public, the freedom of choice of both patient and physician.

3. To guard and preserve the patient-physician relationship with its innumerable benefits consistent with the professional standards established by the corporation.

4. To work in conjunction with the Pennsylvania Medical Society, which is a non-profit organization, with county medical societies throughout the Commonwealth, and with other organizations in developing and promoting the art and science of medicine, the protection of the public health, and the improvement of the medical profession.

5. To research and study the financing and service delivery methods of all plans — be they government, private health insurance, or other prepaid medical care — which are based on freedom of choice for both subscriber and provider, and which guarantee the best of the physician-patient relationship. The goal of the research and study would be to further promote the above foundation programs.

6. To work with and provide the information to the public, governmental health agencies, union organizations, and other groups and individuals, concerning the reasonable cost of adequate medical care.

7. To negotiate, establish, and carry out contracts consistent with the foundation's purposes with any person, group, association or corporation, or any branch or subdivision of local, state or national government.

8. To handle all of the duties involved in administering medical, health and service plans for its members under such things as group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or other group arrangements.

9. To establish a standard procedure by which any person receiving medical or health services has the opportunity for a fair hearing in any disputed instance.

PMS Activity

The Pennsylvania Medical Society named a subgroup of its Council on Medical Service to act as foundation directors until the normal procedures specified under the articles of incorporation can be applied for the election of directors or trustees.

Any Pennsylvania licensed physician or dentist who is a member of the Pennsylvania Medical Society, the Pennsylvania Osteopathic Medical Association, or the Pennsylvania Dental Association, or who is eligible for membership in any of the three organizations, will be eligible to apply for election to participating membership in the foundation corporation.

The Pennsylvania Medical Society plans to incorporate and organize this foundation so that it would be capable of operating as a health maintenance organization if and when such legislation is passed.

In March of 1971, the Pennsylvania Medical Society received a letter inviting it to apply for funds to operate an extensive health care review program in the state. The letter came from Paul J. Sanazaro, M.D., director of the National Center for Health Services Research and Development of the Department of Health, Education, and Welfare. Dr. Sanazaro's center is directed toward improving the access and quality of health and medical care and toward moderating the cost of such services. The center particularly is interested in mechanisms for health care review and proposes to support the establishment and operation of approved experimental review organizations by several medical societies or other interested groups. The Pennsyl-

vania Medical Society has expressed interest in participating in the research program and has submitted a major grant proposal. If the grant should be made, it is planned to incorporate this function within the operation of the medical care foundation.

Group Practice Plans

Various governmental agencies have shown increased interest in group practice plans as a means of improving the delivery and quality of health care. Attention to these plans has been growing since the National Advisory Commission on Health Manpower reported in 1967 that the Kaiser Permanente Medical Care Program was able to provide quality, comprehensive medical care at a cost that was 20 to 30 percent less than other delivery systems in California.

In 1969, the American Medical Association conducted a survey of group practices in the United States. It mailed a questionnaire to 7,891 known or potential groups. It asked the size of the group, specialty composition, location, form of organization, administration, type of medical service provided, extent of prepayment, and the number and type of allied health manpower employed. It received a response of 97.3 percent and analyzed all of the usable answers — a total of 6,371 questionnaires.

The group practice definition used by the AMA Council on Medical Service is as follows: "Group medical practice is the application of medical services by three or more physicians formally organized to provide medical care, consultation, diagnois, and/or treatment through the joint use of equipment and personnel, and with the income from medical practice distributed in accordance with methods previously determined by members of the group."

The AMA divided the 6,371 groups to be analyzed into three basic categories: (1) single specialty groups, (2) general practice groups, (3) multi-specialty groups. The groups involved 40,093 physicians of whom 91 percent were engaged in full-time group practice. The greatest number — 60.7 percent were in multi-specialty groups, with 32.6 percent in single specialty groups, and 6.7 percent in general practice groups. Two-thirds of the total number of groups were in five states — California, Texas, New York, Ohio, and Illinois.

In Pennsylvania there were 231 groups, of which 139 were single specialty, 65 multi-specialty, and 27 general practice. The total number of physicians in Pennsylvania groups was 1,364, of which 748 were in multi-specialty units, 527 in single specialty groups and 89 in general practice groups.

Only a small number of the 6,371 groups analyzed were prepayment groups. A prepayment group, by any other name, is a type of health maintenance organization — and all of the pros and cons of health maintenance organizations that I have cited apply equally to any prepayment group. Regardless of how you feel about health maintenance organizations — whether you be an avid proponent or extreme opponent — it is clear they are not the single answer to our health care problems. In support of that, I will quote from a paper delivered by C. C. Culling, M.D., executive director of the Permanente Medical Group:

"Much of the interest and inquiry into the concept and mechanism of this type of health care delivery has been legitimate and rational. Unfortunately, a greater portion of the attention has been a superficial hailing of group practice prepayment as the panacea for all the ailments of the American health care industry. I obviously feel that group practice prepayment has considerable advantages over other systems of health care delivery. If not, I would not have devoted the past 32 years to such a program. But to blindly jump on the bandwagon of prepaid group practice to the exclusion of all other systems and hail it as the solution to the ills of national health care — as many are wont to do — is not only intellectually dishonest but a detriment to those who are honestly seeking answers to the question of how we can improve the accessibility and delivery of medical care. In the lexicon of our younger generation — it is a cop out."

Non-Urban Impact

Outside of the major metropolitan centers of Pennsylvania, there has been an understandable but deplorable growing physician shortage due to a variety of complex causes that cover the gamut of social, economic, and medical education reasons. The further we move away from urban centers and their attractive suburbs, the greater the shortage becomes until it hits almost crisis proportions in isolated rural sectors.

In group practice lies the only immediate practical means of stopping or even reversing this maldistribution of available medical manpower. The solo practitioner moving into one of these isolated areas literally can be worked to the point of exhaustion, surrounded every minute by frustration over his inability to use all of his medical knowledge because of the inaccessibility of consultants and supportive services. With a group practice program in an isolated area, that physician can join the group with assurances that his time can be budgeted without imposing hardships on his patients and with assurance that consulting services immediately are available.

In this reference to group practice, I am not differentiating between fee-for-service and prepayment groups. It is the environment provided by the group itself which offers the inducement for a physician to join it, and the reimbursement arrangement is only a component of that total environment. It is an environment that is essential for attracting physicians to rural areas. True, the availability of physicians in rural areas might be solved in a non-voluntary way by drafting physicians and assigning them to specific areas but I believe that the best voluntary solution is the promotion and growth of rural group practice.

Just as all patients are not alike, physicians are not alike and not all of them will or should choose to practice in a group. There always will be solo practitioners providing their care with a self-reliance and patient involvement that have been the keystone of primary medical care. Medical school curricula of today and our total culture provide too few such individuals to continue to rely on solo practitioners for the delivery of medical care in rural America.

In cities and their suburbs, group practice may be an optional method. In some rural sectors, group practice well may become the only method. □

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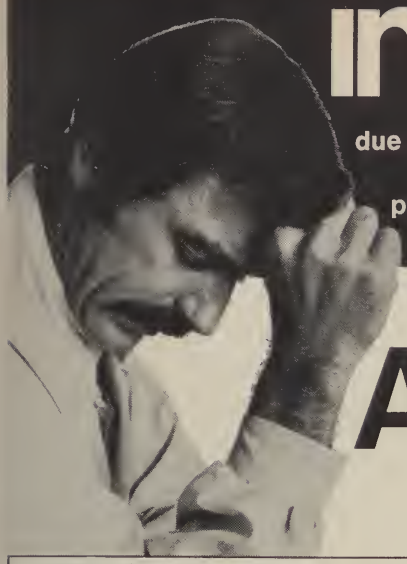

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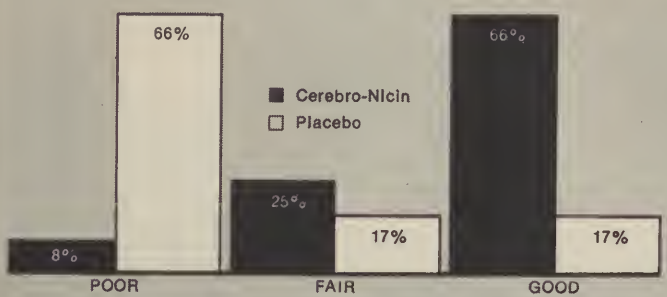

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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir 8 oz. bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

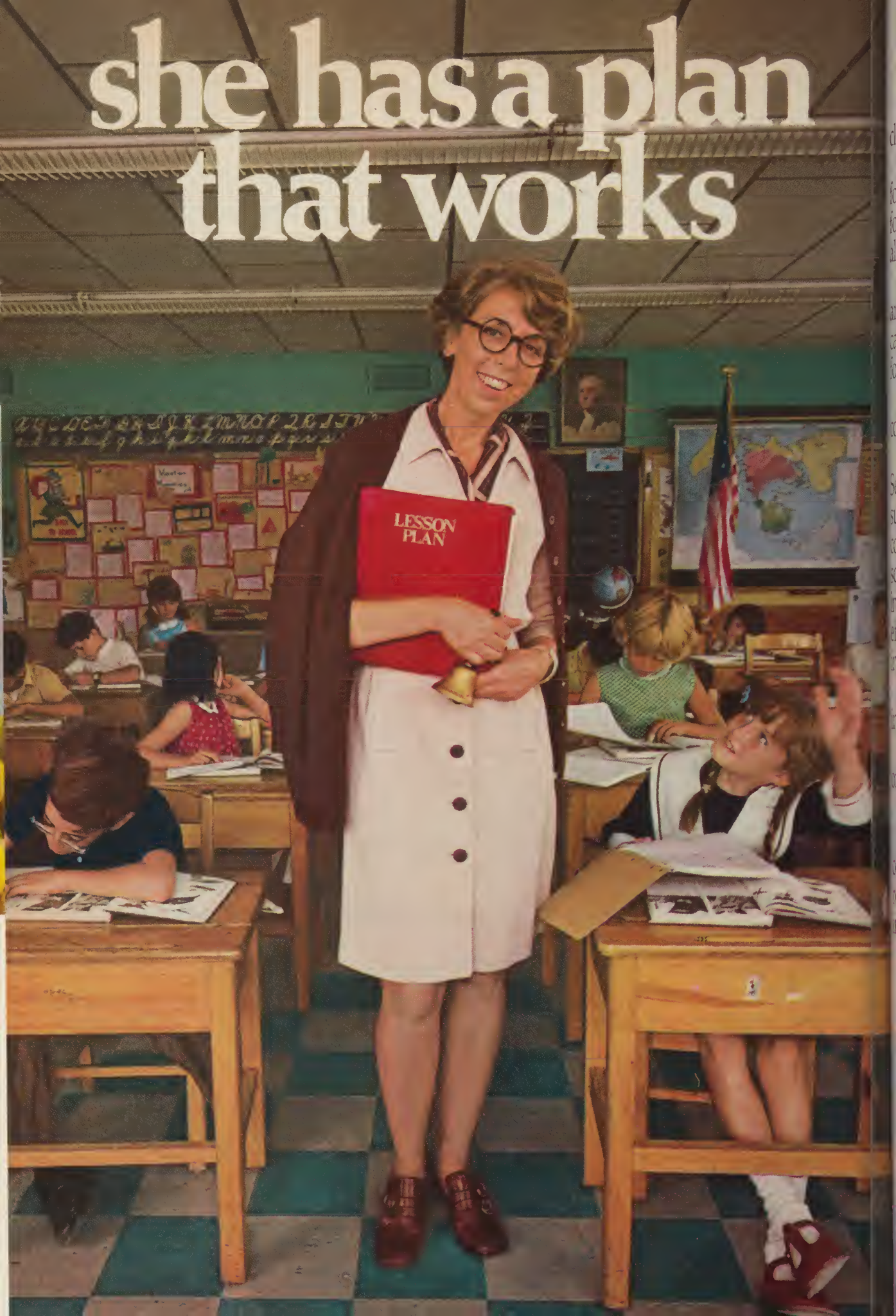
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

Write for literature and samples...

BROWN **THE BROWN PHARMACEUTICAL CO.**
2500 W. 6th St., Los Angeles, Calif. 90057
Write for Product Catalog

she has a plan that works



She has a plan that works.

She has one plan for the class. And they really respond.

She has another plan just for herself. A medication plan for her hypertension. And she's also responding beautifully.

More than just another antihypertensive, Ser-Ap-Es can be a whole medication plan for living with hypertension.

Does it get good marks for comfort?

Excellent. Because Ser-Ap-Es controls blood pressure effectively, dosage of each component is lower than if prescribed alone, usually minimizing side effects. However, side effects may occur (see prescribing information).

Designed with the kidney in mind?

Hydralazine maintains or increases renal blood flow.

And the brain too?

Hydralazine also relaxes cerebral vascular tone. And reserpine has beneficial calming action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

Practical on a teacher's salary?

Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits…

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

C I B A

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

a plan for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

INDICATIONS: All cases of hypertension except the mildest and the most severe.

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

Hydralazine: Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Reserpine: The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydralazine: Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

Hydralazine: Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and nonrigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Reserpine: Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

Hydralazine: Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE: One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

SUPPLIED: *Tablets* (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

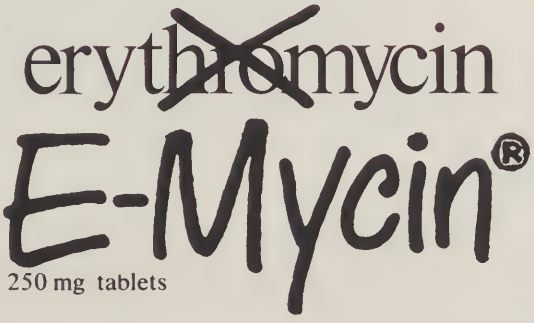
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901 —2/4624-1 17

she has a plan that works for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

CIBA



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E-Mycin® available in 250 mg tablets.

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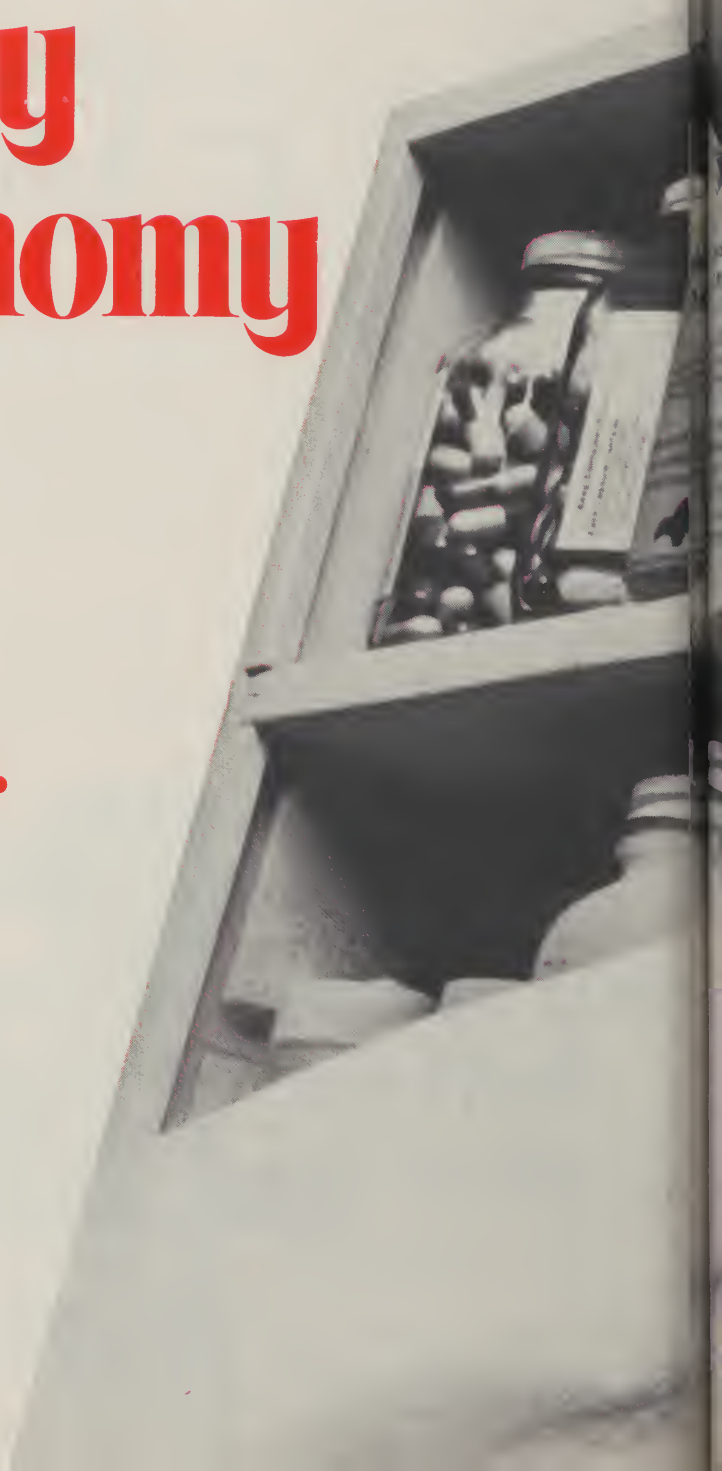
Kalamazoo, Michigan 49001

Upjohn

Guide his hand to quality and economy



Specify Deltasone® 5 mg. (prednisone, Upjohn)

an economical prednisone that's made a name for itself

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

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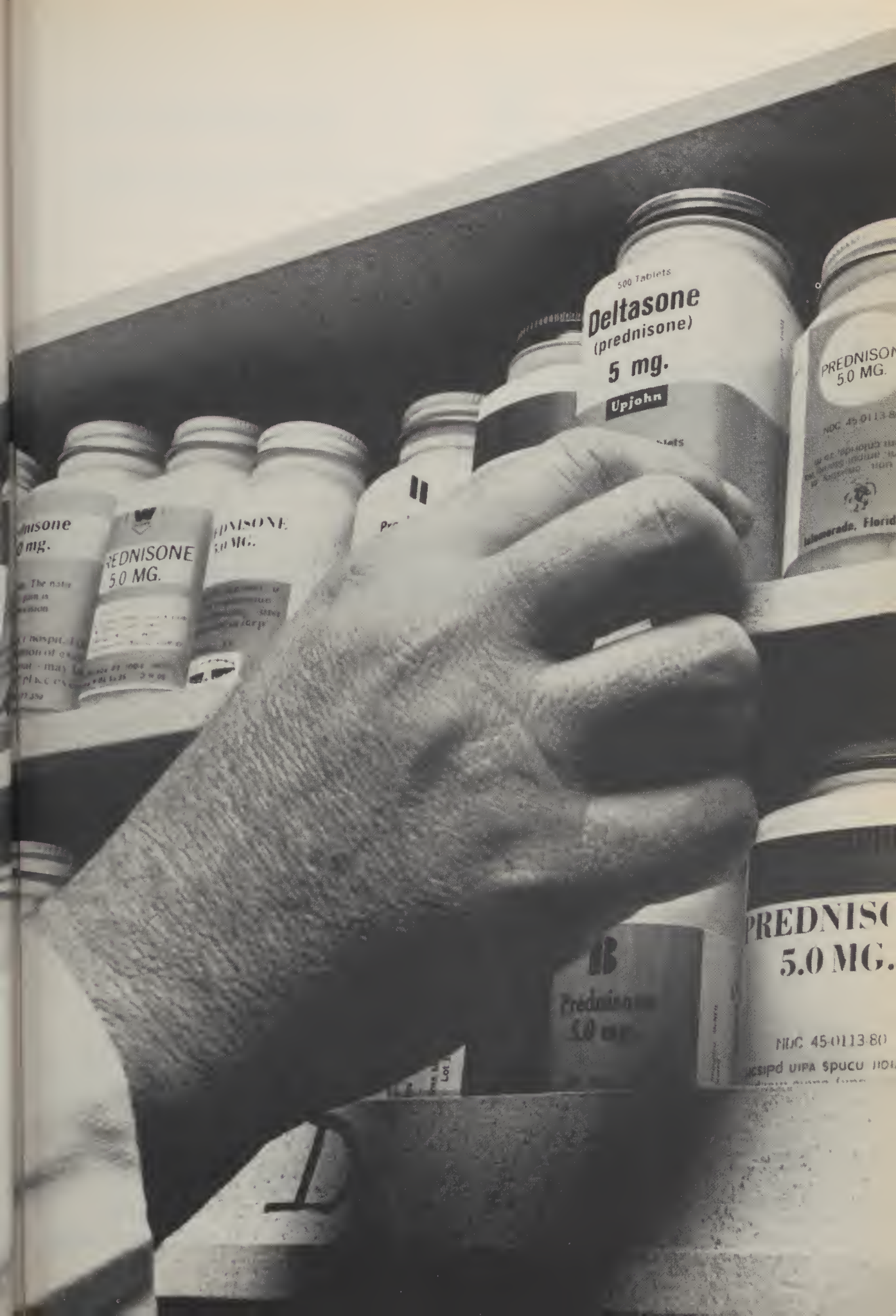
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(prednisone)
5 mg.
Upjohn
PREDNISONE
5.0 MG.
PREDNISONE
5.0 MG.
PREDNISO
5.0 MG.
NDC 45-0113-80

DELTASONE® TABLETS—2.5 & 5 mg.
(prednisone, Upjohn)

The potency of prednisone exceeds cortisone in glucocorticoid and anti-inflammatory activity by about five times on a weight basis, but is considerably less active than cortisone in mineralocorticoid activity.

Indications are the same as those for other anti-inflammatory steroids. Representative uses include collagen diseases, allergic diseases, generalized dermatoses, acute ocular inflammatory disease, certain lymphatic neoplastic diseases, ulcerative colitis and nephrosis. *Important:* Prednisone, like cortisone, is a potent therapeutic agent influencing the biochemical behavior of most, if not all, tissues of the body. Because it manifests little sodium-retaining activity, the usual early sign of cortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of cortisone apply to Deltasone (prednisone).

Contraindications: As for all other corticoids. *Considered Absolute*—herpes simplex keratitis, acute psychoses and latent, healed or active tuberculosis. May be lifesaving in certain cases of pulmonary or meningeal tuberculosis, but should be used only in conjunction with adequate and effective antituberculous therapy to which causative organisms are shown to be sensitive. *Considered Relative*—active or latent peptic ulcer, Cushing's syndrome, diverticulitis, fresh intestinal anastomoses, osteoporosis, renal insufficiency, thromboembolic tendencies, psychotic tendencies, diabetes mellitus, hypertension, local or systemic infections including vaccinia, varicella and other exanthematous diseases, and fungal infections, and, pregnancy particularly during the first trimester because of observation of fetal anomalies in experimental animals. If necessary to give corticosteroids during pregnancy, watch newborn infants closely for signs of hypoadrenalism and institute appropriate therapy if signs appear.

If corticoids are used in the above conditions, weigh risks against benefits.

Precautions: Deltasone should be given only with full knowledge of characteristic activity of and varied responses to corticoids. Because of inhibiting effect on fibroplasia, corticoids may mask signs of and enhance spread of infection; hence, watch patients closely, and if intercurrent infection occurs, control with appropriate antibacterial measures. If possible, avoid abrupt cessation of corticosteroid therapy because of the danger of superimposing adrenocorticoid insufficiency on the infectious process. Prolonged hormone therapy usually causes a reduction in the activity and size of the adrenal cortex. When discontinuing therapy, relative adrenocortical insufficiency may be avoided by gradual reduction of dose. However, a potentially critical degree of insufficiency may persist asymptomatically for some time even after gradual discontinuation of adrenocortical steroids. Therefore, if a patient is subjected to significant stress, such as surgery, trauma, or severe illness while being treated, or within one year (occasionally up to two years) after treatment has been terminated, hormone therapy should be augmented or reinstituted and continued for the duration of the stress and immediately following it. Since mineralocorticoid secretion may be impaired, salt and/or desoxycorticosterone should be administered conjunctively. It is preferable to use a soluble hormone preparation in the immediate preoperative and postoperative periods.

Although unlikely with Deltasone, average and large doses of corticosteroids can cause elevation of blood pressure, salt and water retention and increased potassium and calcium excretion. Dietary salt restriction and potassium supplementation may be necessary. Glucocorticoid steroids may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. Corticosteroids may aggravate myasthenic symptoms in myasthenia gravis and should be given with proper precautions.

Muscle weakness, in some instances, attributed to hypopotassemia, has been reported following prolonged systemically administered corticoids. Excessive potassium loss, like excessive sodium retention, is not likely to be induced with effective maintenance doses of Deltasone (prednisone), however, keep this eff in mind and perform periodic serum potassium determinations patients on prolonged corticoid therapy. Muscle weakness occ ring with normal serum potassium levels may be due to disturbar in muscle metabolism. Severe myopathy is associated with su stantial doses of steroids for prolonged periods, and evider indicates it occurs more frequently with 9-alpha-fluro steroids. F placement with non-fluorinated steroid has, in some instances, sulted in improvement.

Retardation of linear growth, roughly proportional to dose, h been noted in children on corticoids for six months or more. Follc ing cessation of therapy, growth rate may be accelerated. The fore, carefully observe growth of children on prolonged cortic and if growth is retarded, reduce dose sufficiently to permit recov before epiphyseal closure. Make every effort to avoid cortico during pregnancy, since spontaneous remission of some diseas such as rheumatoid arthritis may occur. Long term corticoid thera may evoke hyperacidity or peptic ulcer, therefore, as prophylax an ulcer regimen and antacid are highly recommended. Take X-ra in peptic ulcer patients complaining of gastric distress, a whether or not changes are noted, an ulcer regimen is reco mended. Since prednisone causes less salt and water retenti than many other glucocorticoids, patients should be observ closely for development of undesirable hormonal effects that a less obvious indications of steroid toxicity than edema and hyp tension due to salt and water retention. Continued supervision patients after cessation of therapy is essential, since there may a sudden reappearance of severe disease manifestation.

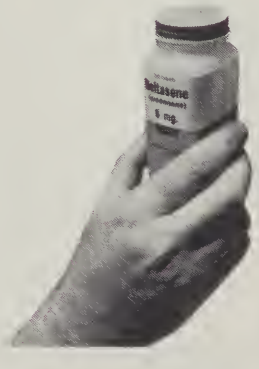
Adverse Reactions: Adverse reactions associated with use of co coids include: Cushing's syndrome, moon facies, supraclavicu fat pads, hirsutism, striae and acne; relative adrenocortical insu ciency particularly in time of stress due to trauma, surgery severe illness; protein catabolism with negative nitrogen balan electrolyte imbalance; alteration of glucose metabolism with agg vation of diabetes mellitus including hyperglycemia and glycosur osteoporosis reversible only with difficulty; spontaneous fracture aseptic necrosis of the hip and humerus; activation and complic tion of peptic ulcer including perforation and hemorrhage; agg vation or masking of infection; increased blood pressu convulsions; petechiae and purpura; menstrual irregularities cluding amenorrhea, spotting or prolonged bleeding; insomn psychic disturbances especially abnormal euphoria; nervousnes posterior subcapsular cataracts occasionally requiring extracti increased intraocular tension; increased intracranial pressure w papilledema (pseudotumor cerebri); pancreatitis; necrotizing an itis; thinning of scalp hair; suppression of growth in childr thromboembolic complications; facial erythema; allergic skin rea tions; ulcerative esophagitis; sweating; vertigo; weakness; myc athy; headache; exophthalmos. Adverse reactions are usua reversible and usually disappear when drug is discontinued.

Supplied: 2.5 mg., scored—bottles of 100 tablets. 5 mg., scored bottles of 100 and 500 tablets and cartons of 100 tablets in f strips.

For additional product information, consult the package ins or see your Upjohn representative.

MED B-1S (KQ

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001



Deltasone® 5 mg. (prednisone, Upjohn

an economical prednisone that's made a name for itself

IN ASTHMA
IN EMPHYSEMA

optional therapy

THE mudranes®

All Mudranes are bronchodilator-mucolytic in action, and are indicated for symptomatic relief of bronchial asthma, emphysema, bronchiectasis and chronic bronchitis. **MUDRANE tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **Iodide side-effects:** May cause nausea. Very long use may cause goiter. Discontinue if symptoms of iodism develop. **Iodide contraindications:** Tuberculosis; pregnancy (to protect the fetus against possible depression of thyroid activity). **MUDRANE-2 tablets** contain 195 mg. potassium iodide; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline. **Iodide side-effects and contraindications are listed above. MUDRANE GG tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline; 21 mg. phenobarbital (Warning: may be habit-forming); 16 mg. ephedrine HCl. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions** are those for aminophylline-phenobarbital-ephedrine combinations. **MUDRANE GG-2 tablets** contain 100 mg. glyceryl guaiacolate; 130 mg. aminophylline. **Dosage** is one tablet with full glass of water, 3 or 4 times a day. **Precautions:** Those for aminophylline. **MUDRANE GG Elixir.** Each teaspoonful (5 cc) contains 26 mg. glyceryl guaiacolate; 20 mg. theophylline; 5.4 mg. phenobarbital (Warning: may be habit-forming); 4 mg. ephedrine HCl. **Dosage:** Children, 1 cc for each 10 lbs. of body weight; one teaspoonful (5 cc) for a 50 lb. child. Dose may be repeated 3 or 4 times a day. Adult, one tablespoonful, 4 times daily. All doses should be followed with ½ to full glass of water. **Precautions:** See those listed above for Mudrane GG tablets.

MUDRANE—original formula

First choice

MUDRANE-2

When ephedrine is too exciting or is contraindicated

MUDRANE GG

During pregnancy or when K.I. is contraindicated or not tolerated

MUDRANE GG-2

A counterpart for Mudrane-2

MUDRANE GG ELIXIR

For pediatric use or where liquids are preferred

Clinical specimens available to physicians.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

For Insomnia... one capsule for the rest of the night

NOLUDAR® 300

(methyprylon)

Before prescribing, please consult complete product information, a summary of which follows:

INDICATION: Relief of insomnia of varied etiology.

CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.

WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.

Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.

Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.

PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.

ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

Each capsule contains 300 mg of methyprylon.

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

★

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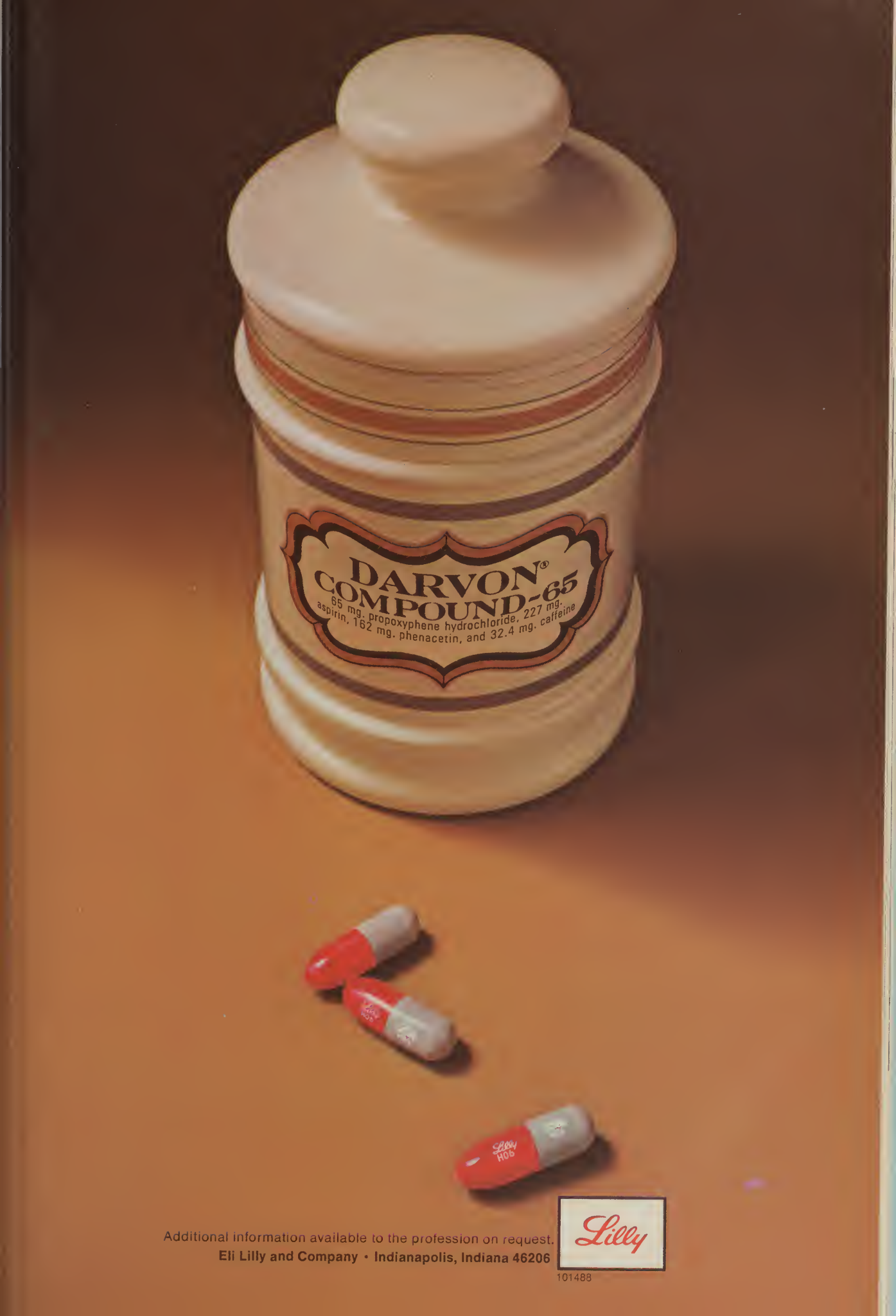

Additional information available to the profession on request.

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Lilly

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gastritis

when G-I symptoms demand a potent synthetic anticholinergic

move up to "the Robinul response"

In treating hypersecretion and hypermotility associated with gastritis are you disappointed in the results you've been getting with some of the synthetics? Then *move up* to a potent anticholinergic—Robinul® Forte (2 mg. glycopyrrolate). It provides prompt, pronounced, prolonged suppression of gastric hypersecretion, making it a highly effective agent in gastritis and other upper G-I conditions associated with hypersecretion and hypermotility. Because Robinul Forte exerts a profound antispasmodic action, it is also useful in the treatment of lower G-I disorders, such as functional bowel distress and spastic and irritable colon. If the patient has a "one tract mind" concerning his condition, you can help control the anxiety and tenseness by prescribing Robinul®-PH Forte (2 mg. glycopyrrolate with 16.2 mg. phenobarbital —warning: may be habit forming).

Robinul® 2 mg. Forte (glycopyrrolate)

INDICATIONS Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily icated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with te episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities ilable, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recom- nded in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; (gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic creatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure drome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital y be indicated. ■ **CONTRAINDICATIONS** Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric reten- , prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH te (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ **PRECAUTIONS** Administer with caution in the presence of incipient ucoma. ■ **SIDE EFFECTS** The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. rred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic gs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsi- s, and rash. ■ **DOSAGE** The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one let three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual ent's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum uired to maintain symptomatic relief. ■ **SUPPLY** Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved R/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue lets engraved AHR/2 in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

You can't fell a redwood with a hatchet
With vitamins, too, relative needs determine the choice.
A low potency vitamin formula may be "a good thing." But when the need for vitamins is great, only a high potency formula will do.
THERAGRAN is often indicated as a high potency vitamin formula pre- and postoperatively, and in many patients with: arthritis, diabetes, pancreatitis, infectious disease, hepatic disease, cardiac disease, degenerative disease, osteoporosis, alcoholism, dermatologic conditions, psychiatric disorders, malabsorption syndrome, peptic ulcer, ulcerative colitis, other gastrointestinal disease, and during the menopause. Also available with minerals as THERAGRAN-M.
Theragran®
High Potency Vitamin Formula
Theragran®-M
High Potency Vitamin Formula with Minerals
THERAGRAN TABLETS AND LIQUID CONTAIN 600% OF THE MINIMUM DAILY ADULT REQUIREMENT OF VITAMIN C.
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HEALTH SCIENCES
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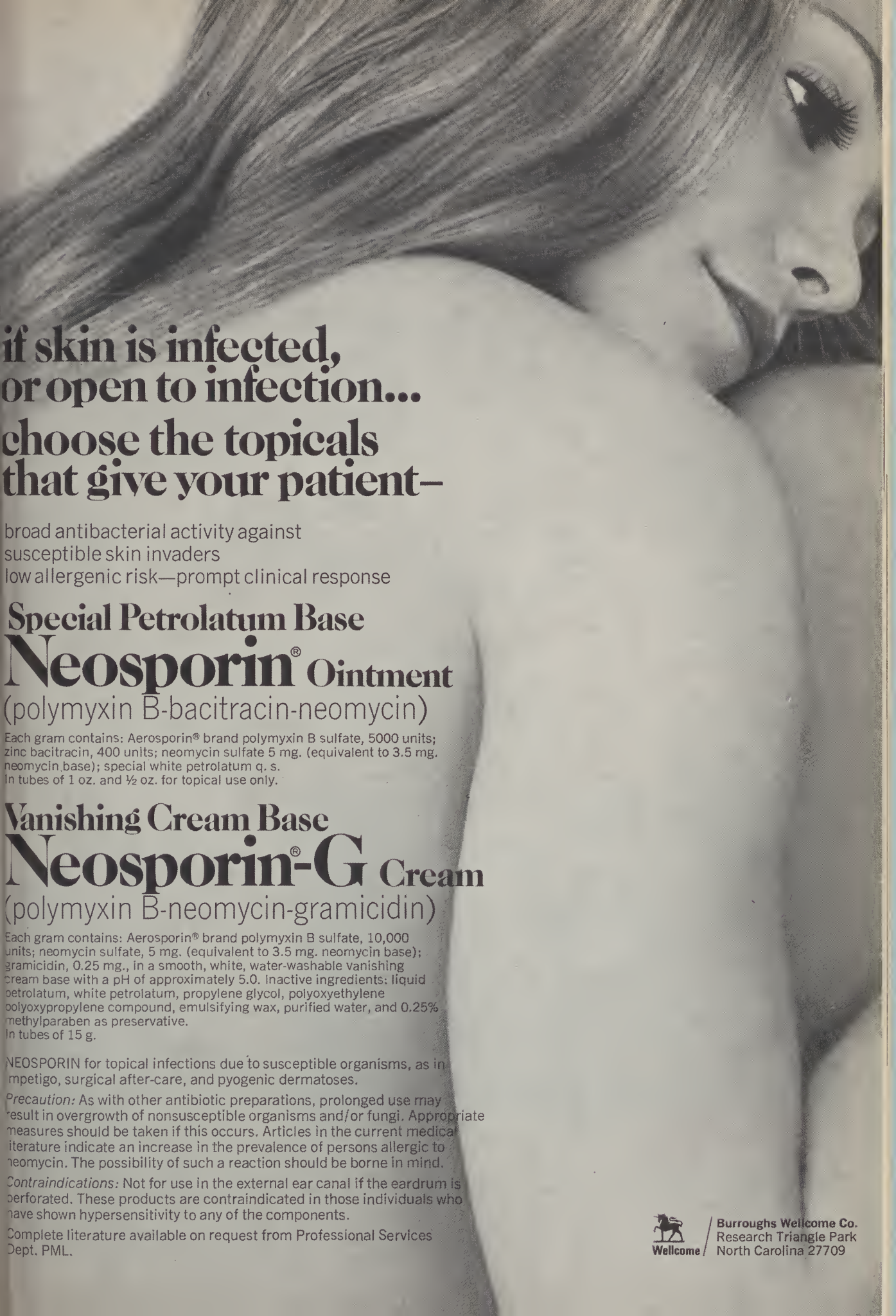

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m.d.'s in the news

A. James Liedtke, M.D., has been appointed assistant professor of medicine at the Milton S. Hershey Medical Center of Pennsylvania State University. He has been a fellow in cardiology at the Peter Bent Brigham Hospital in Boston and an assistant instructor in medicine at Harvard Medical School.

Alumni awards have been presented to several state physicians by area medical schools. The University of Pittsburgh School of Medicine has presented the Philip Hench Distinguished Alumnus Award to **Harry F. Bisel, M.D.**, chairman of the division of clinical oncology and internal medicine at the Mayo Clinic and associate professor of clinical medicine at the Mayo Graduate School of Medicine, Rochester, Minn.

Bucknell University has recognized the service of **Robert L. Gatski, M.D.,** Bloomsburg, superintendent of the Danville State Hospital, in the treatment of alcoholics, the aged, and the mentally disturbed.

Medical College of Pennsylvania has announced two alumnae awards. **Lucy Frank Squire, M.D.,** is the recipient of the 1971 Alumnae Achievement Award for her work in medical education in the field of radiology. She is a lecturer on radiology at Harvard Medical School and Massachusetts General Hospital, Boston, and an associate professor of radiology at the State University of New York. The college's Commonwealth Committee has chosen **Elizabeth S. Waugh, M.D.,** Philadelphia, as the recipient of its citation to an outstanding alumna for her work in the field of obstetrics and gynecology, both in private practice and as an author and teacher.

A number of state physicians have recently received recognition for service to their communities. The General Hospital of Monroe County honored **Drs. Paul Shiffer, Marshall Metzgar, Claus Jordon,** and **Thomas Metzgar** for thirty-five years of service. The Northampton Lions Club has named as their Man of the Year **Thomas Kardish, M.D.,** of Churchville.

A. Eaton Roberts, M.D., Malvern, received a plaque from the Chester County Medical Society for twenty-five years of service to the community, and the Paoli Memorial Hospital dedicated its radiology department to him.

Nathan H. Einhorn, M.D., director of medical education at Philadelphia General Hospital, was honored at a retirement dinner after thirty-five years of service to the hospital.

Joseph E. Beideman, M.D., Norristown ophthalmologist and former president of the Wills Eye Hospital Society, has announced his retirement after more than fifty years of practice.

The Union County Medical Society recently honored **John W. Arbogast, Sr., M.D.,** Lewisburg, for more than fifty years of service. His son, **John W. Arbogast, Jr., M.D.,** is a member of the staff at Evangelical Community Hospital, where his father practiced and served on the board of directors for over thirty-two years.

Other foreign lectures of interest have been reported by St. Christopher's Hospital for Children in Philadelphia. **Robinson D. Harley, M.D.,** professor of ophthalmology at Temple School of Medicine and chief of the section of opthalmology at St. Christopher's, was guest speaker representing Project Hope at a recent meeting of the Trans Carribean Ophthalmic Society in Kingston, Jamaica.

Victor H. Auerbach, M.D., research professor in pediatrics and chief of biochemical research at St. Christopher's, chaired a session and presented a paper at a meeting of the International Symposium on Malignant Hyperthermia at the University of Toronto.

The Pennsylvania Radiological Society has announced the election of the following officers at its annual meeting held in May at the Bedford Springs Hotel, Bedford: **Drs. Herman C. March,** Philadelphia, president; **Edgar L. Dessen,** Hazleton, president-elect; **John H. Feist,** Pittsburgh, and **Marston T. Woodruff,** Philadelphia, vice-presidents; **Theodore A. Tristan,** Harrisburg, secretary; **Ross H. Smith, Jr.,** Pittsburgh, treasurer; and **Donald G. Ferguson,** Pittsburgh, editor. Councilors elected were **Drs. Gilbert H. Alexander,** Pittsburgh; **Luther W. Brady,** Philadelphia; **Lester M.J. Freedman,** Pittsburgh; **John H. Harris, Jr.,** Carlisle; and **William T. Thorwarth,** Philadelphia.

William P. Barba, M.D., Jenkintown, and **Samuel S. Herman, M.D.,** Penn Valley, have been selected as associate vice presidents for Temple University's Health Sciences Center.

AWARDS FOR EXCELLENCE were presented by Irving Woldow, M.D., left, coordinator of medical education at Albert Einstein Medical Center to Gangaiah Natarajan, M.D., native of India, chief resident at AEMC, and by Julius Klein, AEMC president, to Morris Rossman, D.O., intern, at House Staff Graduation ceremonies.

Edward B. Polin, M.D., clinical associate professor of medicine at Temple University School of Medicine, has received a $500 grant from the Christian R. and Mary F. Linback Foundation for distinguished teaching. The Linback Foundation also presented a $1000 clinical award to **Harry Gottlieb, M.D.,** clinical associate professor of medicine at the Medical College of Pennsylvania, on the occasion of its commencement exercises.

The University of Pittsburgh School of Medicine gave its Golden Apple Award for teaching excellence to **Paul C. Gaffney, M.D.**, professor of pediatrics. Former acting chairman of the department of pediatrics and former medical director of Children's Hospital, Dr. Gaffney has been honored by Pitt medical students for the second time with this award.

The 1971 annual award from the National Board of the Medical College of Pennsylvania was given to **Barbara Ruben Migeon, M.D.,** associate professor of pediatrics, for her work in pediatrics, in the teaching of medicine, and her contribution to medical research.

The United Kingdom's highest award in pediatric surgery, the Denis Brown Gold Medal was presented to **C. Everett Koop, M.D.,** surgeon-in-chief at Children's Hospital of Philadelphia. Dr. Koop is professor of pediatric surgery at the University of Pennsylvania School of Medicine.

WALTER B. SHELLEY, M.D., Philadelphia, left, professor and chairman of dermatology at the University of Pennsylvania School of Medicine and Lawrence Parish, M.D., right, associate in dermatology and medical historian, hold one of the wax representations of skin diseases used for teaching purposes in the nineteenth century. It is one of the collection made by Louis A. Duhring, M.D., the first professor of dermatology and founder of the first clinic for skin diseases at the University of Pennsylvania in this country. The occasion was the centennial celebration of the founding of the clinic.

Two Williamsport physicians presented medical diplomas to their sons at Temple School of Medicine's graduation. **William D. Todhunter, M.D.** made the presentation to his son, **Richard Boyd Todhunter,** who will intern at St. Christopher's Hospital for Children in Philadelphia. **Philip Jacobson, M.D.,** presented a diploma to his son, **Robert Jacobson,** who plans to intern at Baylor Center in Dallas, Texas.

Prizes for scientific studies of the Eastern section of the American Congress of Rehabilitation Medicine were awarded recently at Thomas Jefferson University School of Medicine. Among the winners were **Chao-Son Teng, M.D.,** chief resident, and **Martin Grabois, M.D.,** and **John Seeber M.D.,** both of Philadelphia, and both residents at Moss Rehabilitation Hospital.

Russell P. Green, M.D., and **Stanley F. Peters, M.D.,** accepted a public service award presented to the Bucks County Medical Society in recognition of its support of local Red Cross Safety programs.

William D. Lewis, M.D., Philadelphia, has been certified as a fellow in the American College of Anesthesiologists.

A fourth edition updating the textbook for medical students entitled *Obstetrics and Gynecology* has been published. Coauthors are **J. Robert Willson, M.D.,** Ann Arbor, Mich. **Clayton T. Beecham, M.D.,** of the Geisinger Medical Center, Danville and **Elsie Reid Carrington, M.D.** Medical College of Pennsylvania.

meetings

SEPTEMBER

The American Association of Obstetricians and Gynecologists, **September 9-11,** Hot Springs, Va.

World Medical Association, **September 13-17,** Ottawa, Canada.

Annual Meeting, Pennsylvania Chapter of the American Academy of Pediatrics, **September 18-19,** Hershey Motor Lodge, Hershey. For further information: write James J. Reilly, M.D., secretary, 3520 Laketon Rd., Pittsburgh 15235.

American Academy of Ophthalmology and Otolaryngology, **September 20-24,** Las Vegas, Nev.

Pennsylvania Academy of Dermatology, **September 24-26,** Pocono Manor.

The American College of Cardiology and Temple University School of Medicine— Program on cardiopulmonary disease, **September 27-28,** Philadelphia. For further information: contact Mary Anne McInerny, 9650 Rockville Pike, Bethesda, Md.

Seventh National Cancer Conference, **September 27-29,** Biltmore Hotel, Los Angeles, Cal. For further information: write Sidney L. Arje, M.D., Coordinator Seventh Annual Cancer Conference c/o American Cancer Society, 219 East 42nd St., New York, N.Y. 10017.

The American Roentgen Ray Society, **September 28-October 1,** Boston, Mass.

OCTOBER

The American Academy of General Practice, **October 1-8,** Miami Beach, Fla.

Annual Session Pennsylvania Medical Society House of Delegates, **October 4-6,** Pittsburgh Hilton Hotel, Pittsburgh.

The American College of Surgeons and Cornell University School of Nursing, **October 7-9,** Commodore Hotel, New York, N.Y. For information: write New York-Brooklyn Regional Committee on Trauma of the A.C.S., P.O. Box 588, Lenox Hill Station, New York, N.Y. 10021.

Annual Meeting of Industrial Health Foundation, **October 12-13,** Chatham Center, Pittsburgh. For information write: Robert T.P. deTreville, M.D., president, Industrial Health Foundation, 5231 Centre Ave., Pittsburgh 15232.

The American Academy of Pediatrics annual meeting, **October 16-21,** Palmer House, Chicago, Ill.

Gallbladder contrast dyes and acute renal failure

In this issue of Pennsylvania Medicine the paper by Schiro et al calls attention to the problem of acute renal failure following the administration of cholecystographic agents. The pathogenesis of acute renal failure following the use of these agents in the radiographic examination of the biliary system has not been established. However, recent attention has been focused on the uricosuric effect of these dyes.

A causal relationship has been postulated between the uricosuric effect and the development of acute renal failure in some patients. The majority of cases have occurred in patients who have either received repeated doses on successive days or have been associated in patients with hepatic insufficiency. Even if an acute uric acid nephropathy is not responsible for every case of cholecystographic nephrotoxicity, its potential for causing acute renal failure cannot be minimized.

Usual practice calls for the administration of the oral cholecystographic agents in the early evening. Frequently, in the routine performance of the study, the directions call for fluid restrictions following ingestion of the tablets until completion of the examination the next morning.

Additionally, nausea and diarrhea are common side effects to the agents, further contributing to the reduction of the patient's blood volume. Since the uricosuric effect is prompt in onset, it will peak during the night at a time when the urine is most concentrated and acidic, further increasing the hazard of urate precipitation in the renal tubules.

Based on present information, it would appear that maintenance of an adequate urine flow, use of proper medical indications when ordering the cholecystographic studies and identification of high risk patients will be essential in reducing this hazard. Further studies are warranted to determine the extent of the problem and the necessary steps to avoid this serious adverse reaction.

DAS

The rehabilitation road

It is well known that there is great need for increased facilities to provide services for alcoholism— the nation's most widespread public health problem— and there are some indications of growth of such services. Yet it remains a fact that even existing services are not functioning at their optimum, primarily because of a lack of coordination of services.

Three salient points should be remembered in caring for the alcoholic patient. First, alcoholism, at least at the stage at which it is presently being identified, is, like diabetes, a life-long disease. Second, during the life history of this disease, various services may be needed at various times. Each provider of service has his unique part to contribute. The physician has his role in the medical evaluation and restoration of physiologic functions interfered with by alcohol, and in detoxification. The alcoholism or mental-health clinic, psychiatrist or psychologist serves by evaluating the patient's psychologic status and providing the indicated treatment. Residential treatment centers offer intensive psychotherapy. Halfway houses provide resocialization. Groups such as Alcoholics Anonymous give fellowship in helping the individual, over the long haul, to adjust to the various stresses and frustrations encountered in everyday life, without having recourse to emotionally anesthetizing chemicals. The third point is that the transition from one service to another must be smooth and uninterrupted. It would be well to conceptualize services to the alcoholic patient as similar to an electrical circuit: The slightest gap in continuity may render the entire apparatus non-functioning.

It is characteristic of the alcoholic to deny his lack of control over alcohol, and this denial tends to reassert itself many times during his lifetime. As a result, there is great risk of the patient emerging from any phase of treatment with the illusion, "I have now had *the* cure," and conclude that he need not move on to the next phase. A written referral and recommendation to the next link in the chain of services may never be acted upon.

The coordination espoused here is not that of administrative organization at a governmental level, although that is, of course, essential. What is referred to here is that there be a coordination of services, at the local community level, *for every patient*. For each patient, there should be some *one*, whether physician, probation officer, industrial personnel director etc., who assumes responsibility for assuring that the patient proceeds, without interruption, from one phase of treatment to the next. This is not requiring that any one person provide all the necessary services, which is clearly impossible, but that the patient not lose the gains of any service, by falling through the hiatus resulting from fragmentation of services.

In alcoholism, perhaps even more than in any other malady, comprehensive care *and* continuity of care, are the *sine qua non* for recovery.

Abraham J. Twerski, M.D.
Pittsburgh

'Let George say it'

A confusing commissioner

When Insurance Commissioner Herbert Denenberg first appeared to public view in the Philadelphia Blue Cross hearings, it seemed that this was a very badly misdirected young man. Anyone who would put down the medical profession so cold-bloodedly had to be really confused. Imagine suggesting that doctors should pay the salaries of residents in hospitals!

A little later we began to get a slightly different picture. It was certainly high time that someone gave some attention to the overbearing insurance companies who are perpetually raising rates. Then when he lit into the legal profession, it was apparent that this official, though in error once, had some very good impulses. It was a surprise to see one who was established as a "doctor baiter" suddenly show some very intelligent social consciousness. Of course, when you think about it, even in the Blue Cross hearings, he did inveigh against hospital administrators, who, as we all know, are hardly saints, and the Blue Cross, which, perhaps, is even less so.

Now Dr. Denenberg is leading another crusade, this time for no fault auto insurance. The insurance companies are not sure where this will lead them and they are reserving any statement. The claims attorneys are in no way reserved. Their opposition is loud and clear. Their arguments are a little confusing, aimed more at the greedy than at the needy.

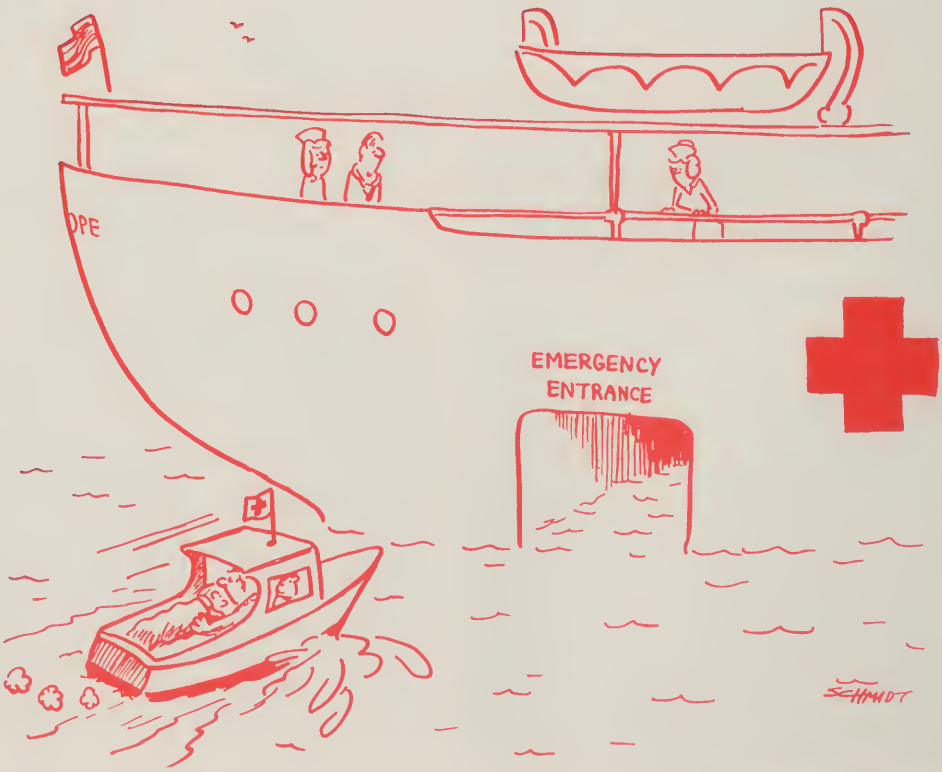
It seems to me that no fault insurance would have two advantages. 1. Quick reimbursement for costs of accidental injuries, and 2. A sharp reduction in the crowding of civil courts. Another benefit that would not be shared by the plaintiff's advocate is the reduction in legal fees.

It is said that laws make civilization possible. As with other virtues, the excess of law can strangle civilization. The adversary system for injury liability is expensive of time and money. It slows courtroom procedure and seldom produces added benefits for the injured. The same can be said of our divorce procedures. To force two people who already have bruised each other to fight in public like gladiators is a cruel and senseless process that multiplies tragedy.

Very slowly we are progressing toward a realization that every deviation from the usual does not necessarily imply an evil act by someone. Accidents usually result from the combined efforts of all participants plus extraneous matters such as weather and physical condition. If our courts were freed of car accidents, divorce, and most other liability cases, judges would be able to give more attention to serious crime.

Naturally enough, our legislatures are heavily laden with plaintive attorneys. Much of their living comes from liability cases and they are in no hurry to remove them from the courts. Dr. Denenberg, a professor turned public official seems determined to accomplish this. I hope he may develop a better opinion of doctors, but I wish him well in this insurance project at any rate.

GAI



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Warning: Irreversible deafness can occur. Tinnitus or vertigo may also occur and indicate vestibular damage and impending deafness. The risk is sharply increased with renal dysfunction. In such cases, decrease size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. Watch carefully for ototoxicity in older patients and patients receiving more than 15 Gm. of kanamycin. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in post-operative patients until recovery from anesthesia and muscle relaxants is complete. Avoid concurrent use of other ototoxic drugs including ethacrynic acid. Safety in pregnancy is not established

Indications: Serious infections due to susceptible strains of *E. coli*, Proteus sp., *Enterobacter aerogenes*, *K. pneumoniae*, *Serratia marcescens* and *Mima Herellea*. Culture and sensitivity studies should be performed.
Contraindications: A history of hypersensitivity to the drug. Prior auditory damage by kanamycin or other agents may be a contraindication if effective alternative therapy is available.
Precautions: Obtain audiograms before and during therapy in patients with renal dysfunction when treatment lasts more than 5 days. Stop Kantrex if tinnitus or hearing loss occurs. Hydrate patients to prevent chemical irritation of the renal tubules. Assess renal function periodically, both before and during therapy. If signs of renal irritation occur (casts, cells, proteinuria) increase hydration and reduce the dosage or the frequency of dosage if necessary – in azotemic patients the frequency (in hours) of doses may be obtained by multiplying the serum creatinine by 9. If azotemia or oliguria occur, discontinue therapy. Mycotic or bacterial superinfection may occur.
Adverse Reactions: Irritation or pain at the injection site, skin rash, drug fever, headache and paresthesias.
Dosage and Administration: The maximum total daily dose should not exceed 1.5 Gm. by all routes of administration. The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gm. daily. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours.

If no response occurs in 3 to 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours. The drug should not be physically mixed with other antimicrobials.
Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations. 0.5 Gm. in 2 ml. and 1.0 Gm. in 3 ml. Also available – Pediatric Injection 75 mg. in 2 ml.

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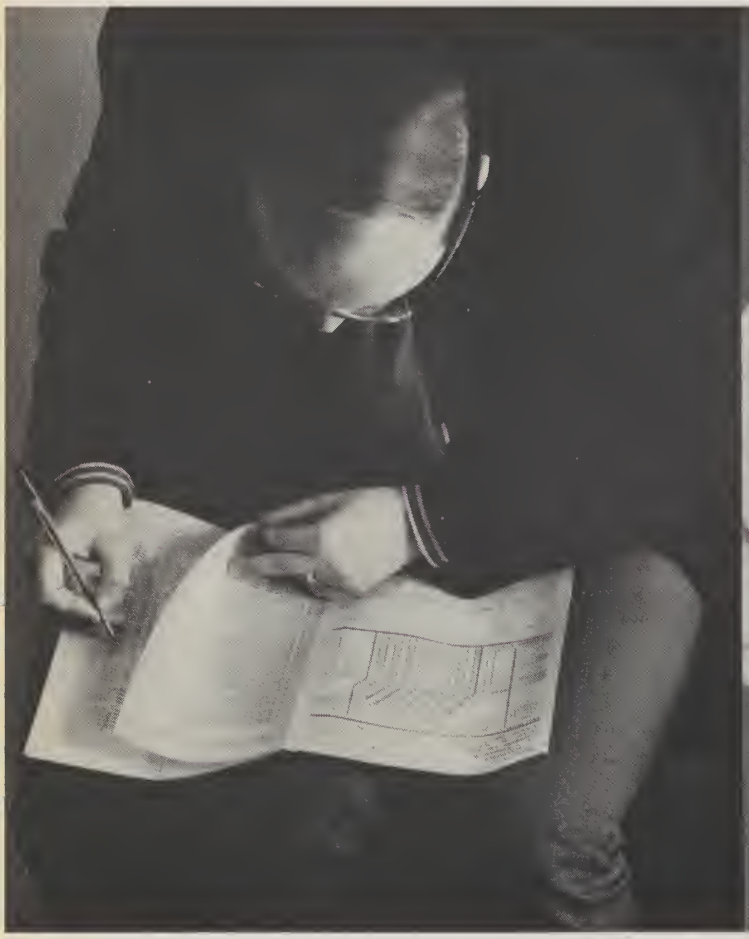

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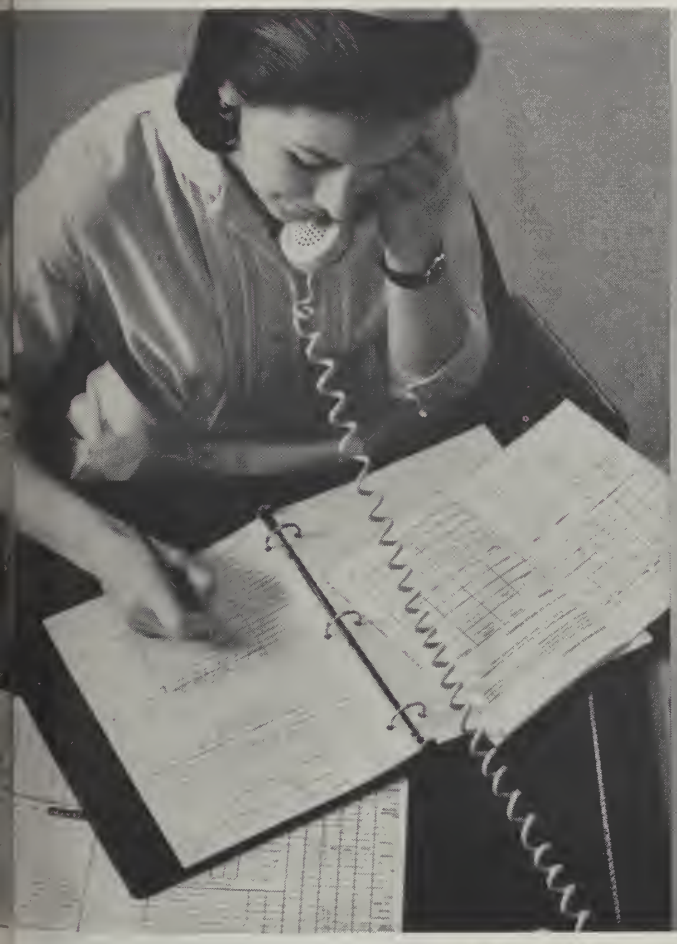

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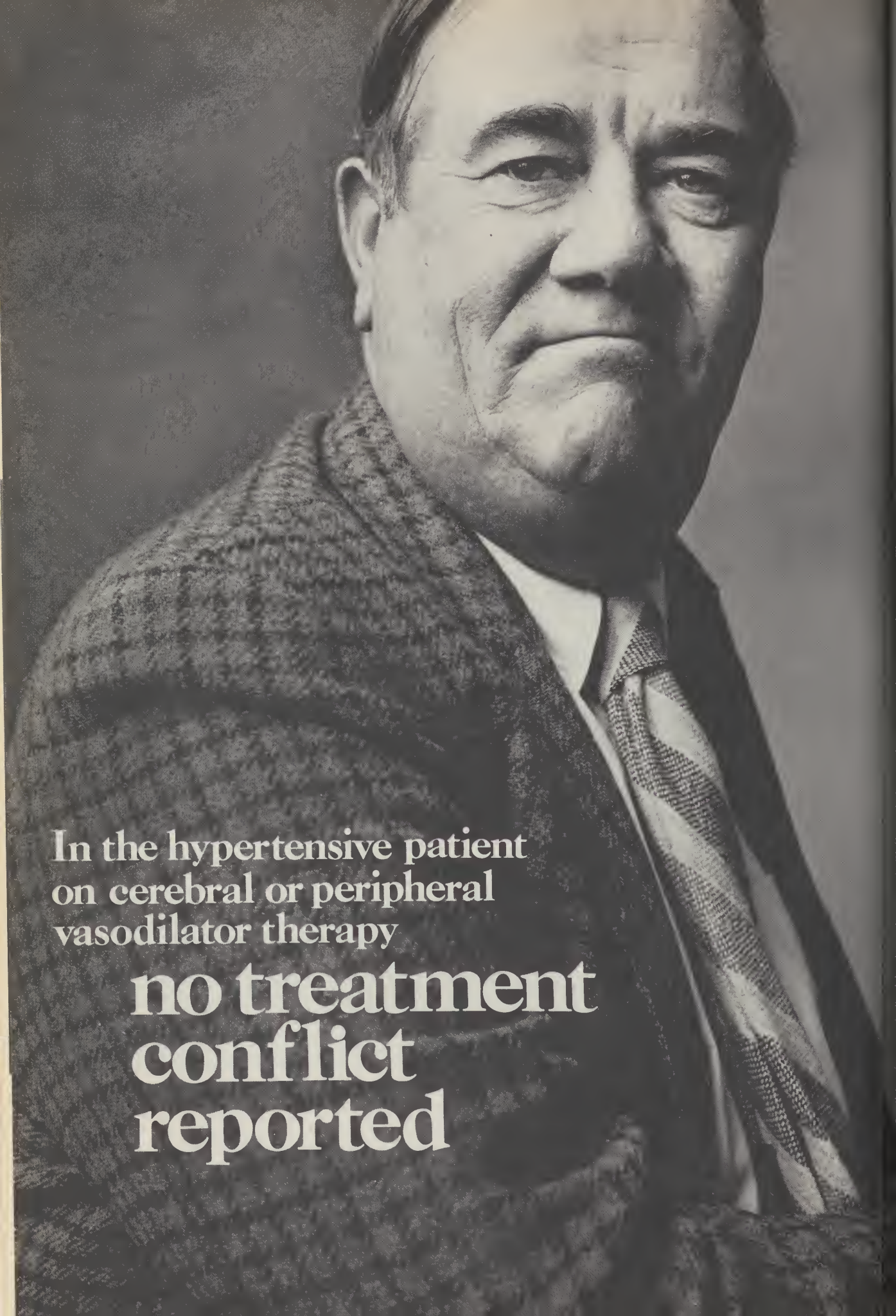
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NOTE: Not recommended during the acute recovery phase following myocardial infarction. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible. Should not be given to patients who have received an MAOI within two weeks.

Contraindications: Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

Precautions: When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be exaggerated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as perphenazine, concurrently.

When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, and 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives.

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A Case Report

Transient Renal Insufficiency Secondary to Iopanoic Acid

JOHN C. SCHIRO, M.D.
JOSEPH A. RICCI, M.D.

THEODORE A. TRISTAN, M.D.
DANIEL M. LEVIN, M.D.

Harrisburg

Dr. Schiro is a resident in medicine at the Harrisburg Polyclinic Hospital. Dr. Ricci is senior clinical instructor at Hahnemann Medical College and Hospital, Philadelphia, and assistant in the Department of Hematology at Polyclinic Hospital. Dr. Tristan is director of the division of radiology at Polyclinic, a clinical professor in radiology at the Milton S. Hershey Medical School of Pennsylvania State University, and associate professor of radiology at Hahnemann. Dr. Levin is clinical assistant professor at Hahnemann Medical College and assistant chief of renology at Polyclinic Hospital.

SEVERAL REPORTS in the literature (1, 2, 4, 5, 6, 9, 10, 13) have implicated orally administered cholecystographic agents as a cause for acute renal failure. However, to our knowledge, none of the previously reported cases has clearly implicated iopanoic acid (Telepaque® Winthrop Laboratories) *in recommended doses* as the sole causative agent. The purpose of this paper is to record a case of transient renal failure secondary to iopanoic acid.

Case Report

S.L., a 66-year-old caucasion male was admitted to the Harrisburg Polyclinic Hospital on March 14, 1971, following an episode of epigastric pain unresponsive to antacids and antispasmodics. The pain was described as dull, constant, non-radiating and was unassociated with additional gastrointestinal symptomatology. Past medical history revealed an hiatal hernia, an appendectomy, a right inguinal herniorrhaphy, a right iridectomy and a cholecystostomy in 1946 for cholelithiasis. The only other pertinent medical history was that of mild labile hypertension. The patient's only medication, prior to admission, was a multi-vitamin supplement.

Physical examination revealed a well developed, well nourished, caucasion male in no acute distress. Vital signs were: temperature 97°, pulse 88, respirations 20, and blood pressure 150/90. Positive physical findings were limited to the abdomen, where epigastric tenderness to deep palpation, without rebound, was elicited. There were no masses noted and bowel sounds were normal. Well healed scars were present from the previously mentioned surgery. Initial impression was hiatal hernia with reflux esophagitis and possible recurrent cholelithiasis.

Laboratory parameters obtained following admission were as follows: Hgb 16.4 gm%, Hct 49.1 vol%, RBC 5.3 million/cc, WBC 15,900/cc with 83% polymorphonuclear leukocytes, 14% lymphocytes and 3% monocytes. A platelet count was 225,000/cc. Urinalysis revealed pH 6, negative albumin, glucose and occult blood. Microscopic sediment contained bacteria and epithelial cells. Serum bilirubin was 2.8 mg% total. The blood urea nitrogen (BUN) was 8 mg%. Serum uric acid was 5.8 mg%. Electrolytes were within normal limits. ECG was normal. Chest film was normal and upper gastrointestinal series revealed an hiatal hernia with mild gastroesophageal reflux.

On the day following admission the patient was given a standard adult dose of iopanoic acid (Telepaque®) consisting of six 500 mg tablets (total 3 grams). As per routine, the patient was maintained NPO after midnight. The gallbladder failed to visualize. Two days following admission, the patient was again given six 500 mg tablets of iopanoic acid (total 3 grams). As before, the gallbladder did not visualize. The patient developed a low grade fever (100°-101° oral) on the afternoon following the second dose of iopanoic acid. The possibility of cholecystitis was entertained and the patient was given Tetracycline 250 mg PO every six hours.

DATE	3/15	3/20	3/22	3/23	3/24	3/25	3/26	3/28	3/29	3/31	4/2	4/6
VALUE												
BUN mg%	8	94	100	78	50	31	23	17	15	17	11	
URIC ACID												
mg%	5.8	11.6						5.3	5.8	5.3	3.2	
SERUM CREATININE												
mg%				5.8		2.6	2.2	1.0				1.1

During the ensuing 48 hours the patient became confused, slightly obtunded and developed herpetiform lesions about the mouth. Two days following the second dose of iopanoic acid the BUN had risen to 95 mg%, the serum uric acid was 11.6 mg% and the bilirubin fell to 0.8 mg% total. Further evaluation was delayed until the acute renal insufficiency could be controlled. The patient was placed on a protein-free diet and was given 5% dextrose in water by venoclysis at a rate of 150 cc per hour for the next four days. The BUN and uric acid levels returned to normal and the oral lesions cleared. (see chart)

Following the return of the BUN to normal the patient underwent an exploratory laparotomy. A cholecystocolonic fistula with surrounding abscess and multiple adhesions were found and resected. The major portion of the gallbladder was necrotic. After an uneventful post-operative course the patient was discharged in good condition.

Discussion

This case presents the occurrence of acute renal insufficiency in a previously healthy 66-year-old male following the ingestion of two daily doses, of three grams each, of iopanoic acid. The only other drug administered to the patient during the period was tetracycline. Although tetracycline can precipitate renal failure in a patient with pre-existing renal impairment, it is not reported to cause insufficiency in people with normal renal function. Shils found that tetracycline, in normal individuals, caused a protein catabolic effect at two to four gram per day dose levels. This resulted in mild transient elevation of the BUN to levels not exceeding 35 mg% but without evidence of actual renal failure (11). Our patient received only fifteen 250 mg doses at six hour intervals (1 gram per day).

A number of case reports in the literature implicate oral cholecystographic agents as causes of acute renal insufficiency (1, 2, 4, 5, 6, 9, 10, 13). However, only two instances have implicated iopanoic acid alone. Rene and Mellinkoff described a case of acute renal failure secondary to a double dose of iopanoic acid, but there was a prior attempt at visualization with an unknown agent and a history of exposure to carbon tetrachloride (9). Canales et. al. recorded four cases of renal insufficiency following iopanoic acid but these all involved doses in excess of those recommended (2). In our case the patient received only six grams of iopanoic acid and no other cholecystographic agent.

Several mechanisms have been suggested as the reason for acute renal failure following the oral administration of cholecystographic agents. Teplick et. al. postulate that if hepatic clearance of the cholecystographic agent does not occur then systemic hypotension results. This hypotension in addition to the dehydration of the patient leads to renal insufficiency on the basis of ischemic anuria-oliguria (12).

Fink et. al., in a series of controlled experiments on dogs, produced degrees of acute tubular degeneration and excessive albuminous exudate by the administration of eight to ten times the recommended human dose of cholecystographic agents (3). Recently Mudge and Postlethwaite and Kelly attributed the acute renal failure of cholecystographic agents to their uricosuric property (7, 8).

Due to the retrospective nature of this case report, an exact mechanism to explain the renal failure can not be ascertained, particularly in the absence of a renal biopsy. Moreover, with the existence of the oral lesions an allergic response must be considered. Therefore, any of the above explanations may account for the renal failure seen in our patient, but iopanoic acid alone appears to be the causative agent.

The case serves to alert physicians to the possibility of transient acute renal failure secondary to iopanoic acid in recommended doses. This problem of acute renal failure secondary to oral cholecystographic agents also indicates that perhaps a re-evaluation of methods of preparation of the patient is in order. To our knowledge there have been no well controlled studies to determine the necessity for fluid restriction prior to attempts at visualization of the gallbladder. In light of our patient's response to simple hydration and protein restriction and the recent work on the uricosuric effects of oral cholecystographic agents, further study seems necessary concerning the effect of fluids on cholecystographic procedures.

Summary

A case of transient acute renal failure is reported with six grams iopanoic acid (Telepaque®) as the cause. □

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An Eleven Year Progress Report

Hospital Based Premedical Programs

PAUL M. ROEDIGER, M.D., FACP
NANCIE MacBAIN
Abington

Abington Hospital's premedical program offers students a unique opportunity—see a related article on page 15.

HEALTH CARE NEEDS have increased dramatically over the past ten years in the United States. The growth of medical knowledge and use of new complex forms of patient care have produced greater demands upon hospitals and the allied health fields. Many attempts are being made to help improve our methods of treating the increased number of sick patients being seen, but there remains a serious deficit in the number of trained personnel. In recent years many hospitals have organized programs to train graduate nurses and other needed paramedical personnel. Guidance seminars have been organized in many high schools and hospitals to motivate students toward the health care professions.

Career opportunities programs are not new in the health field. However, community-based programs to stimulate student interest in medical careers are somewhat unique and form the basis of this report. A program at Abington Memorial Hospital combining volunteer service and career guidance was organized in 1959 when two local college students worked as volunteers in the Emergency Ward.*

Abington Hospital serves as a Regional Medical Center to a large Philadelphia suburb (population 350,000). It presently has 500 beds, an active staff of 250 physicians, and a house staff of 45 interns and residents. It has a diversified training program including medical and paramedical careers. The addition of college students seemed an appropriate extension of the services the staff was capable of offering.

Program Organization

The plan of the program has been to offer college students, preferably in their second year, an opportunity to participate in a medical care program in a useful manner. It was our intent to have the hospital staff stimulate the student's desire to pursue careers in medicine and other professional health care specialties.

Requirements to enter the program have included:

1) Completion of the second year of college
2) Enrollment in courses leading to potential medical school entrance
3) Exhibition of a mature attitude toward the responsibilities and privileges of the program

Preference has been given to students living in the immediate area.

Each year the local newspapers have carried articles and the local medical society has made its members aware of the existence of the program. Students apply to the Director of Volunteer Services who interviews all candidates. They are later interviewed by the Director of Medical Education and at present, a total of ten are accepted for the summer program. In the past year, two other hospitals in the local area have joined with us so that we mutually are able to accept all eligible

* *MacBain, Nancie and Schumacher L.R., M.D. Hospitals: J.A.H.A. 37: 73, 1963.*

students. Although not intended to screen students, the interviews serve to identify those students with average or above average ability and interest. Emphasis has been given to the average students for acceptance with the hope of further stimulating him to excel in his college studies.

A variety of educational experiences are made available to this group. Each student works a minimum of four hours a week in the emergency ward. Since most have summer employment, assignments are usually on evenings and weekends. A round table discussion with hospital staff members is held one evening a week to familiarize students with subjects related to medical careers. The meetings this past year dealt with the following areas: Indoctrination and general discussion of medical careers, accident ward services, internal medicine, surgery, pathology, radiology, obstetrics and gynecology, pediatrics, and "Your choice."

Opportunities to make evening rounds with the medical or surgical resident are made available. In addition, with special authorization, the student may observe in the operating room. Each student is assigned to a staff physician's office for one day or evening, the physicians selected being primarily family practitioners. In a subtle way it is hoped that some will become more interested in pursuing family practice.

We have also had a Dean of Admissions of one of the area medical schools meet informally with this group. The group has also traveled to the medical school for a tour of its facilities.

Work Responsibilities

The institution of this program represented the first time this hospital had college-age male and female volunteers. Although the Emergency Ward staff was accustomed to working with volunteers, they were initially skeptical about the college students; the students, on the other hand, were anxious to prove that they were sincere and could do a good job. An evening's work consists of taking the initial patient information, making beds and litters, cleaning instruments, transporting patients, running errands, answering phones, and doing the myriad of jobs assigned to volunteers in the department (see table). The student not only observed the various medical and surgical procedures, but they also learned the importance of the physician-patient relationship. They learned to reassure an apprehensive patient and to calm an anxious family. At all times his activities are closely supervised by the nursing and medical staff. He has many opportunities to talk with our intern staff who represent, on an average, graduates from four medical schools.

The director of volunteer services is responsible for the routine scheduling of work, getting clearances for observation periods in the operating room and elsewhere, providing uniforms, and handling other day-to-day problems. The director of medical education serves as a counselor to the students. He is responsible for the staff's participation.

Results

After eleven summers, sixty-six students have participated in this program. They have continued their education as follows. Twelve have graduated from medical school. Two are in residency, five in the Armed Forces, and five in internship. Twenty-five are presently in medical school, and six are graduating this year. Seventeen are in undergraduate school, of whom eight are entering medical school in fall, and one is entering dental school. Nine other students are distributed in other professions, as follows: one chemist, three teachers, one PhD in medical socio-economics, one working for a master's degree, two in business, and one airline pilot. Four are lost to follow-up.

Summary

Many thousands of hours of volunteer service have been given by these college students during hours and months of the year when it is difficult to obtain volunteer help. But more important is what the student has obtained. Much has been written about the art of practicing medicine, yet the average student learns little of this in his premedical and early medical studies. The rewards of medical practice stem not only from scientific achievement but also from the daily interpersonal dealings between the physician and his patients. Experiencing this aspect of health service can influence a student to decide in favor of a career in medicine or an allied health field. It is hoped that more hospitals will start this type of program.

Dr. Roediger is director of medical education and an associate physician in metabolic diseases at Abington Memorial Hospital, Abington. Miss MacBain is director of volunteer services of the American Hospital Association.

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Make beds and litters
Answer the telephone and inter-com and take messages except laboratory and x-ray reports
Put up supplies
Put up suture sets and other equipment
Scrub and clean instruments
Take patients to X-ray and floors
Run errands to X-ray, lab, record room, drug room, etc.
Give patients bed pans, basins, etc.
Take temperatures
Assist doctor or nurse in emergency room when requested to in restraining patient, putting on band-aide, etc.
Make out X-ray, lab and EKG requests with supervision
Aide in cast room

Do Not:

Dispense advice or your own opinion to patient or family
Remove bandages or clean wounds of patient unless specifically requested to by doctor
Shave or prep patients for doctor to treat
Give out drugs (except aromatics when necessary)
Give opinion or advice over the phone to outside party
Bandage wounds except under supervision of doctor or nurse
Give out information on patients to anyone outside of hospital personnel
Witness signatures on operation permits or any other legal documents. □

The FDA— Its Role in Testing

ALEXANDER M. MINNO, M.D.
Pittsburgh

THE KEFAUVER-HARRIS amendments have given the Food-Drug Administration (FDA) the direction to say positively that, in its opinion, a drug is both safe and efficacious. Under the law, until 1962, the FDA did not have to make positive statements about drugs, only negative ones. If the FDA remained silent for sixty days after it received a New Drug Application (NDA), the drug in question was automatically allowed to be manufactured by failure of the FDA to say anything at all — by default, as it were. The 1962 FDA amendments have created many challenges from the public, Congress, pharmaceutical firms, the practicing physician, and various medical groups such as the American Society of Internal Medicine (ASIM). I shall try to discuss some of the problem areas in the spirit of the Kefauver-Harris Amendments.

The decisions of FDA are already felt in every doctor's office in the country. Since the enactment in 1962 of the Kefauver-Harris Amendments, the material required for marketing of the drug must include substantial evidence concerning the effectiveness as well as the safety of the drug in question. With the thought of the consumer and protection of public health, there is a balance between the risk and the benefit which the drug will play if approved for marketing.

The new drug application must satisfy requirements to the patient, to the pharmaceutical company, and to the Food and Drug Administration. A drug may be "new" without necessarily being a new substance. For example, a new use for an old drug— as aspirin for a skin rash. Also an accepted remedy used for years, if manufactured in a new form, such as timed release capsule is considered to be a new drug requiring evaluation by the FDA. Clinical investigation may be required to show that the active substance is released in a slow and sustained manner, and that the capsule is safe and effective as claimed.

A new drug assessment requires the sponsor to submit a form known as "Notice of Claimed Investigational Exemption for a New Drug" (IND).

Accompanying the IND, the preclinical investigations, the chemical compositions and standards as to safety are required as well as animal studies primarily directed toward its safety. The data must demonstrate that there will not be unreasonable hazard in initiating studies in human beings.

Studies of new drugs in man are divided into the clinical pharmacology studies, designed as phase I and phase II, and the clinical trial referred to as phase III. Phase I is the first trial in normal man. It is done in a small number of human volunteers and is primarily concerned with the determinations of biological activity in man and affects such target organs systems as the liver, kidney, the hemopoietic system and the heart. Observations of metabolism are encouraged in Phase I so that this information can be of value in selection of adequate animal species for chronic toxicity studies. Dose range studies then can also be initiated in Phase I.

Phase II studies would be extended to include the initial therapeutic trials on a limited number of patients suffering from the ailment for which the drug is expected to be useful. Clinical protocols are constructed setting forth the deviation of the administration of the drug and the clinical observation and laboratory determinations which are to be made. Here revision determinations as to the plan of investigation and such details as the route of administration and the physical form in which the drug is administered are made.

On the basis of the information from phase I and phase II, a decision must be made as to the desirability of more extensive clinical trials, known as Phase III. These well-planned studies can be the basis of the establishment of a clinical protocol of dosage form, and patient selection. These studies need to satisfy two judgments; 1) Is the drug safe? The word "safe" cannot mean absolutely safe but it means the measurement of the adverse effects against the therapeutic benefits. All gradations of safety and therapeutic necessity are encountered with each drug presenting an individual problem involving a variety of factors. Also safety and efficacy are not specific quantities, inasmuch as the clinical situation is a factor, i.e., methotrexate treatment in a neoplastic disease in comparison to an immunosuppressive disease such as rheumatoid arthritis. So, fewer clinical benefits or a higher incidence of adverse reactions with same drug varies somewhat with the disease being treated.

In all clinical trials, the goal or clinical expectation is important to define at the onset. In this assessment, the physician or "the clinical pharmacologist" is involved in the drug trial, based on his knowledge and understanding of the usual history of the disease entity in which the drug is being tested. The factors of placebo with the aura of a test drug in comparison to the benefit of a test drug is a worthwhile consideration to demonstrate drug efficacy.

The FDA in 1970 approved thirty-one new drug applications of which fourteen represent new entities. Among them are developed L-DOPA for Parkinson's disease, lithium carbonate for manic depressives, and a low-estrogen oral contraceptive. In comparison, FDA approved only thirty-nine new drug applications in all of 1969, with fifteen new entities.

The package insert has created much controversy. For instance, a drug may be of value in treating heart disturbances, while approved only for a general use by the FDA. The FDA takes the stand that if the doctor takes a drug and uses it for something else other than the approved conditions, the

FDA wants to know about this. Here the FDA seeks to require the physician to file investigational new drug application when they use a drug for a purpose not stated on the label. The legality of the package insert is being challenged by the AMA's Department of Drugs on the basis that there is nothing in the law that obligates the doctor to file the investigational new drug claim form. One legal expert states that the real power of the package insert lies less in its authority over the physicians prescribing practice than in its use in malpractice suits. It is a fact that court decisions in drug injury cases show that great weight is given to the question of whether the physician used the drug as recommended in the manufacturer's labeling in determining whether there was negligence. Perhaps a statement that the package insert is a guide, not a binding directive, would be helpful. Or the local hospital staff committee could approve the drug use because of the clinical judgment involved. However, it would seem right that for a totally new use of a drug the FDA should require the physician to file an IND form.

The 1962 Drug Amendments states, in effect, that a drug which on October 9, 1962 was commercially used and sold in the United States was not a new drug, and was not covered by an effective new drug application. The new criterion of effectiveness would not apply to such a drug when intended solely for use under the conditions prescribed, recommended, or suggested in the labeling with respect to such drug on that day. This so-called "Grandfathers Clause" has given protection to a pre-1962 drug as being safe by virtue of being an old drug. A review of the effectiveness of drugs marketed between 1938 and 1962 is being sponsored by FDA by the National Academy of Sciences - National Research Council. This is a lot of work, since some 3,000 pre-1962 drugs are currently being evaluated as part of the efficacy study. The promise is to publish in the Federal Register all of the 3,000 plus reports by July 1971, at the latest. It is estimated that clinical scientific review on all of them has been completed. This could mean thousands of actions by FDA— from a clear-cut case of an ineffective drug being removed from the market to a possible effective drug with the manufacturer being urged to initiate studies to obtain information needed for determining the drug status.

The fixed combination-drugs have been the subject of much recent FDA action including withdrawal from the market. The key issue revolves around the fact that information by medical and scientific experts exists to warrant the drug's continued marketing and the question of whether this opinion provides the data of well-controlled clinical investigations. This unresolved problem has been made the subject of a court test in a law suit brought by the Pharmaceutical Manufacturers Association. The report on the "grandfather" drugs could have far-reaching effects for over-the-counter drugs, labeling changes, expenditures for animal and clinical studies, FDA, "Dear Doctor" letters (expenses between $30,000 and $35,000 per letter), and for many adjustments in the physicians' prescribing concepts.

In the past, the FDA had encouraged "a compendium of therapy," but this interest apparently has subsided. However, legislation keeps being introduced in one congressional bill or another, the latest being a formulary to contain listing by established name of drugs necessary under federal health care programs. This amendment, by Senator Russell B. Long, would, if enacted, establish a national formulary. The U.S.P. with its tremendous prestige would indeed be an ideal organization to promote a compendium, and at its recent meeting it forwarded a resolution to this effect to the U.S.P. Board of Trustees. The USP would have to liberalize some standards to include more drugs in the same class and accept more equivalent drugs; as an example— at present there are only 8 barbituates in U.S.P.

Dr. Minno is rheumatology consultant at Harmarville Rehabilitation Center, Pittsburgh, and clinical instructor of medicine at the University of Pittsburgh School of Medicine. He has served as chairman of the Parmaceutical Committee of the American Society of Internal Medicine since 1968.

The 1961 "Full Disclosure" regulation also requires all promotional labeling for a prescription drug— which is employed at the manufacturers option, including mailings to physicians and publications such as Physician Desk Reference, to furnish substantially the same information as that approved for the drug package insert. Bound by these 1961 "package insert" and "full disclosure" regulations, PDR has been revising its publication with constant improvements, such as listing of generic equivalents, photos for easy identification of drugs, and periodic supplements to update its contents. Presently PDR is used by hospital house staffs and practicing physicians as a major source of information in prescribing drugs. There are limitations to the drug package labeling as a medium for communicating to physicians reliable drug prescribing information, but there is no authority in law to require more direct communication except on written request from a physician to a manufacturer. Perhaps an outline form of usual, common, rare, adverse effects would be helpful to the practicing physician. The fine print of the package insert makes the reading difficult. A streamlining of the package insert or allowing PDR to publish something other than the "package insert" would be most helpful.

The conflict of FDA, USP, PDR, and the pharmaceutical firms do not appear as great as the news media would imply. The publicity in the papers about the hazardous side effects of drugs does unduly frighten patients and eclipses to some extent the beneficial aspects of drugs. Consumer protection appears to be the sole objective with the entire drug environment being involved. Gone are the days when the method of development of a new drug was left almost entirely to the drug manufacturer. We could also ask ourselves— Have we gone too far and are the legal standards granted by Congress too rigid? Can the drug standards be set by National Academy of Sciences (National Research Council) and is this real drug testing or are there better priorities for these august bodies to follow? The answers to these questions are not available. Perhaps with time, the many moves by the FDA could have a cheerful impact on medical care. □

Surgical Treatment of Coronary Sclerosis

Part II

William H. Sewell, M.D., Chief of ardiac Surgery, Guthrie Clinic, Ltd. d Robert Packer Hospital, Sayre, ennsylvania, is questioned by William . Leaman, Jr., M.D.

ow strong is your evidence that vein afts to coronary arteries improve ognosis?

It is not strong enough to convince eptical critics, but I am convinced at our own data, plus that being accumulated at Cleveland Clinic, Marquette University, and other centers, is howing that coronary surgery has nproved prognosis, and vein grafts are ncreasing life expectancy by severalold. Those familiar with the field can ee a clear-cut difference between vein rafts and earlier surgical procedures or myocardial ischemia. I think that a ardiologist is more likely to be wrong f he applies the assumption that the rognosis is as good with medical mangement, instead of referring suitably ndicated cases for surgery.

What is the patency rate of these grafts?

Reported patency rates are in the 80 nd 90 percent range and are improving teadily. All surviving postoperative paients have been studied arteriographically, and 91 percent of our 146 grafts have been proved patent. All of the 59 patients having double grafts have had at least one patent, and 88 percent have had both patent. We have considered coronary arteries as small as 1.0 mm. in diameter as acceptable. Not attempting the smallest arteries would increase the graft patency rate.

What are the chances of late closure?

One-year arteriographic studies show that under 10 percent of those patent early postoperatively are closed at one year. There is good reason to think that the subsequent closure rate will be very low.

Do some patients need triple vein grafts?

I do believe we really know the answer to this. My tentative conclusion has been that there are few, if any, patients who need three. However, the long-term prognosis should be better with three, and we will probably do many in the future if the additional risk can be made negligible.

Do these operations relieve angina?

Yes. The vast majority of patients with arteriographically successful vein grafts have had complete relief of angina.

How much trouble have you had with late myocardial infarction and death?

Of 80 patients discharged alive from the hospital, there was one death following intestinal gangrene, but no other deaths and no recognized infarctions.

Is there any place for internal mammary implantation by the Vinebery or pedicle technic?

I doubt it, but I realize that this opinion is contrary to some authorities in the field.

Is there any evidence that vein grafts improve over-all cardiac physiology?

Yes, very definitely. Often improvement in ventricular function is quite obvious in a postoperative ventriculogram. More detailed studies show marked improvement in myocardial function and relief of ischemic lactate production. We have learned that it often is not possible preoperatively to distinguish scar from myocardium that is too weak to contract.

How would you compare coronary vein grafts with heart transplantation?

The vein grafts are less dramatic, but much more practical and, in general, far more satisfactory. There are few, if any, patients who would have a better chance with heart transplantation than with vein grafts.

Do you favor vein graft operations under emergency conditions?

Certainly prompt coronary arteriography and prompt surgery in a patient with preinfarction angina is desirable if the patient fits in the good risk group. So far, the surgical treatment after actual myocardial necrosis seems risky, though some dramatic results have been achieved.

When do you resect a ventricular aneurysm?

In any good risk candidate who has a bulging scar about 6 cm. or more in diameter and who has symptoms because of low-cardiac output or arrhythmia. The results in these cases should be quite satisfactory.

What do you think of the future of coronary surgery?

Satisfactory control of coronary disease by diet and medication is probably several decades away. If the current prognostic trends after vein grafts continue, and the indications for arteriography and surgery outlined herein are applied on a widespread basis, then the potential stress on current medical facilities leads to interesting speculation.

William G. Leaman, Jr., M.D., edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.

The Treatment of Incurable Breast Cancer

Eckles and Fuller of the M.D. Anderson Hospital have recently reported on the treatment of incurable breast cancer at that institution. Their principle aim is improving the quality of survival and in each case they devise a long range plan designed to give immediate symptomatic relief with maximum tumor control and prevention of disabling symptoms. While they consider megavoltage radiotherapy the most useful agent for palliation, their plan integrates radio-therapy with what they call "systemic" treatment (hormone therapy, endocrine ablation, and chemotherapy.)

Incurable primary breast cancer is treated with simple mastectomy when technically feasible and postoperative radiotherapy when indicated by the extent of the lesion. Inflammatory carcinoma beyond the breast is treated systemically.

Chest wall recurrence in and adjacent to the mastectomy scar is treated aggressively unless there has been damage from previous radiation. Extensive recurrence in the skin flap or dermal lymphatic spread are resistant to radiation and are treated with systemic agents.

The treatment of early regional node metastases in the postmastectomy patient is definitive radiotherapy since these are potentially curable. Regional node involvement when general metastases are present is not treated unless they produce symptoms. Thus the aim of treatment is permanent local control with dosage levels to 4000 to 5000 rads. As in chestwall recurrences, diffuse lymphogenous spread is an indication for systemic treatment. If the metastatic involvement is limited to the neck and supraclavicular fossae, radiotherapy is used to prevent or reduce pressure on the blood vessels, trachea, and esophagus. However, if the metastases are very extensive in this area it indicates lymphogenous spread. Radiotherapy is then contraindicated and systemic treatment used.

Intrathoracic metastases involving the lung are not irradiated because of the damage to normal tissue. Chemotherapy is used. For pleural effusions that do not respond to systemic therapy the pleural cavity is obliterated with nitrogen mustard, radioactive gold, or pleurectomy. Involved mediastinal nodes are treated with radiation provided that diffuse lymphogenous spread is not present.

Systemic care is used in those patients not suitable for radiotherapy. The choice of modality, the timing and the sequence are of great importance. In the premenopausal patient with disseminated breast cancer, the first treatment is surgical castration. If there are clinical contraindications to surgery, radiation castration can be used.

Adrenal or pituitary ablation are unpredictable in their response. Good results are more likely if the following criteria are met: (1) an interval of more than two years, free of disease, from initial treatment to first sign of recurrence or metastasis; (2) favorable response to oophorectomy or hormone treatment, and; (3) worsening of the disease under provocative estrogen administration.

Steroid hormones are increasingly effective in the menopausal patient and best results are obtained in patients ten years or more postmenopausal. Chemotherapy is used in those patients unresponsive to endocrine change or who are hormone resistant. Their patients are divided into three groups (1) Those who failed to respond to castration. Methotrexate, 5-Fluorouracil, alkylating agents, androgens and corticosteroids are used in varying combinations. (2) Those who responded initially to castration and are less than five years postmenopausal. All the preceding drugs plus endocrine ablation are considered. (3) All those patients more than five years postmenopausal. All the above plus estrogens are considered.

Your Skin and The Sun

TO: EDITORS AND PUBLISHERS
FROM: THE AMERICAN CANCER SOCIETY

Skin cancer is responsible for 5,000 deaths in the United States in a single year. Yet this is a *preventable* form of cancer. Overexposure to the sun causes most skin cancer. If more people knew this, probably fewer would die.

Will you alert your readers to the dangers of too much sun by publishing these fillers and ads as frequently as you can?

CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.

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Tomato Rice, Old Fashioned

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The Unwanted Child & Birth Control

Ten thousand battered children– a growing medical problem?

In his daily practice the physician witnesses the human suffering caused by uncontrolled fertility. Perhaps one of its most tragic effects is the unwanted child, who so often experiences parental rejection. The rejected child in a family may be neglected, nagged and severely punished. Sometimes he is criminally abused. Child abuse is common enough to have become a separate clinical entity: the "battered child" syndrome. Reliable statistics are difficult to obtain, but it has been estimated that in this country alone roughly 10,000 children are "battered" per year, and their number may be increasing.

A revealing picture of child abuse patterns is provided by one study of the American Humane Society. More than half of the 662 children involved (all reported in newspapers within a single year) were less than 4 years of age. One fourth of the battered youngsters died; most of these deaths were of children less than 2 years of age. Fathers were more often guilty of child abuse than mothers, but sometimes both parents participated. The study indicated that battered children are not limited to any particular socioeconomic stratum.

***For the complete brochure, and others in the series as they appear, please write to Searle or ask your Searle representative.** Explored in the forthcoming issues will be the history of birth control, the influence of poverty, ethnic factors and marital status, its role in illness, its genetic implications and its effects on the emotional and behavioral life of the individual.

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emulen . . . for its low estrogen and Searle's progestin—or Ovulen . . . with its wide physician nd patient acceptance. Both offer almost complete contraceptive effectiveness and a w incidence of side effects. Both with a choice of pill-taking schedules . . . simple Sunday-starting" and patient-proof Compack® tablet dispensers.

Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States nce 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of he combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

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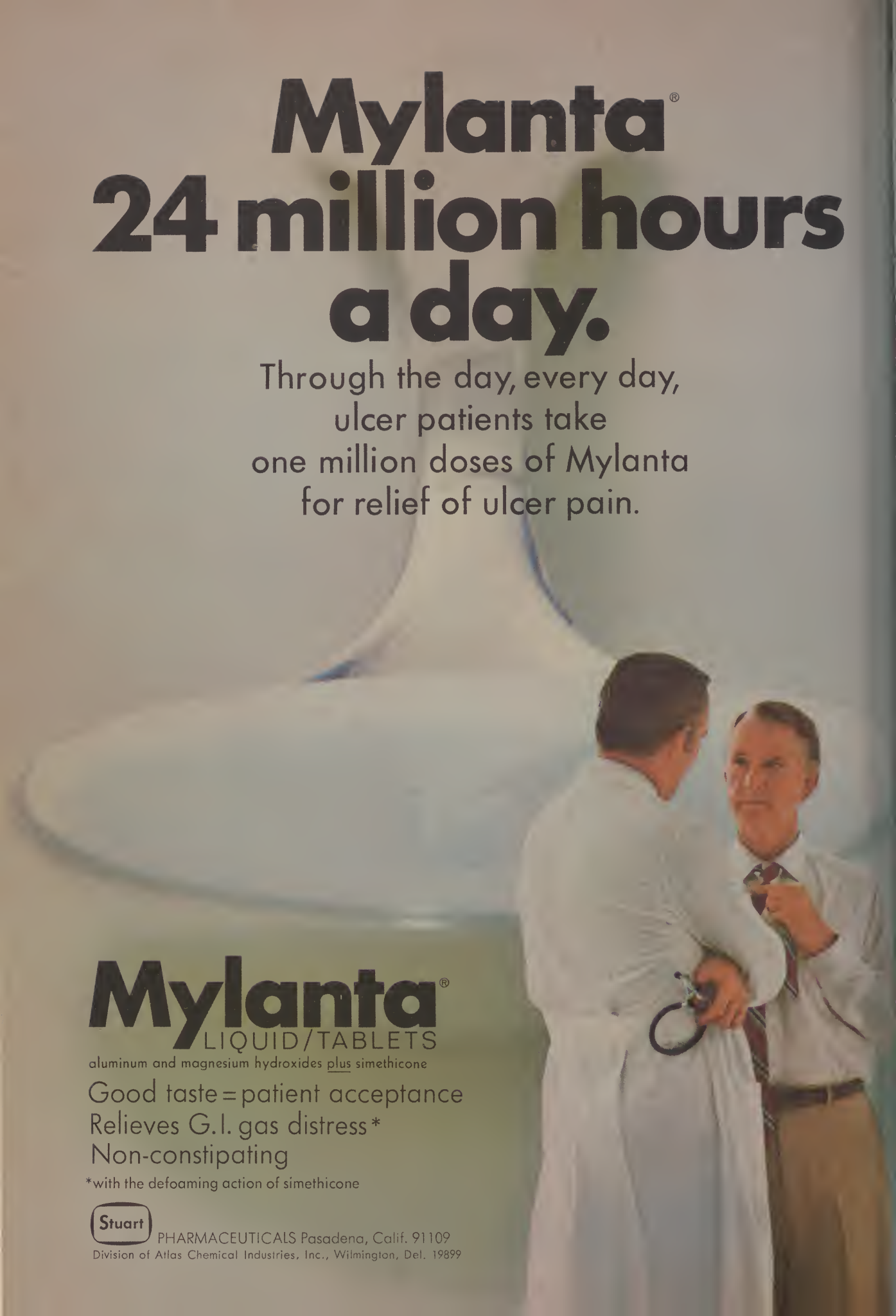

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Annual Session of the House of Delegates

October 4-6
1971
Pittsburgh Hilton Hotel

1971 Annual Business Session Pennsylvania Medical Society

Program

	Sunday, October 3	
1:00 P.M.	Board of Trustees	King's Terrace
6:00 P.M.	PMS Past Presidents' Dinner	Brigade Suite H
	Monday, October 4	
10:00 A.M.	PaMPAC Board of Directors	Brigade Suite H
12:00 Noon	Reference Committee Chairman Luncheon	King's Garden
1:00 P.M. - 8:30 P.M.	Delegates' Registration	Ballroom Foyer
3:00 P.M. - 5:00 P.M.	Second Councilor District Meeting	Chartiers Suite A
3:00 P.M. - 5:00 P.M.	Third Councilor District Meeting	Chartiers Suite B
3:00 P.M. - 5:00 P.M.	Fifth Councilor District Meeting	Traders Room C
3:00 P.M. - 5:00 P.M.	Sixth Councilor District Meeting	Black Diamond Room F
3:00 P.M. - 5:00 P.M.	Seventh Councilor District Meeting	Brigade Suite G
3:00 P.M. - 5:00 P.M.	Eighth Councilor District Meeting	Brigade Suite H
3:00 P.M. - 5:00 P.M.	Ninth Councilor District Meeting	King's Terrace
3:00 P.M. - 5:00 P.M.	Tenth Councilor District Meeting	King's Garden
3:00 P.M. - 5:00 P.M.	Eleventh Councilor District Meeting	Ballroom 1
3:00 P.M. - 5:00 P.M.	Twelfth Councilor District Meeting	Parlor 414
7:30 P.M.	First Session, House of Delegates	Ballroom 1
	Tuesday, October 5	
12:00 Noon - 2:00 P.M.	Delegates' Registration	Ballroom Foyer
8:00 A.M.	Reference Committee on Constitution and By-Laws	Ballroom 4
8:00 A.M.	Reference Committee on Education and Science	King's Garden
8:00 A.M.	Reference Committee on Governmental Relations	LaBateau Lounge
8:00 A.M.	Reference Committee on Medical Service A	Ballroom 2
9:00 A.M.	Reference Committee on Public Service	Chartiers Suite A
9:00 A.M.	Reference Committee on Reports of Standing and Special Committees	Chartiers Suite B
9:00 A.M.	Reference Committee on Reports of Officers	Traders Room C
1:30 P.M.	Special Reference Committee on Medical Service B	Ballroom 3
6:00 P.M. - 7:00 P.M.	State Dinner Reception	King's Garden
7:00 P.M.	State Dinner	Ballroom 1
	Wednesday, October 6	
7:00 A.M. - 9:00 A.M.	AMA Delegation Breakfast	Chartiers Suite A
8:00 A.M. - 1:00 P.M.	Delegates' Registration	Ballroom Foyer
9:00 A.M.	Second Session, House of Delegates	Ballroom 1
	Board of Trustees (following adjournment of House of Delegates)	King's Terrace

Twenty-fourth Annual State Dinner

Tuesday Evening
October 5, 1971

Pittsburgh Hilton Hotel

Reception (compliments of Parker & Co., Inc., of Pennsylvania and Argonaut Insurance Company)

Dinner

Dancing
and Entertainment

- Installation of George P. Rosemond, M.D., as the 122nd President of the Pennsylvania Medical Society
- Presentation of Past President's Medallion to William A. Limberger, M.D., 121st President
- Presentation of State Benjamin Rush Awards

Please reserve _____tickets at $11 per person for the Annual State Dinner banquet.

Name (Please Print) _____

Address_____

City_____County Society_____

(Please make check payable to Pennsylvania Medical Society.)

Summary: 1971 Official Reports Pennsylvania Medical Society

All items appearing in this special section of PENNSYLVANIA MEDICINE are summaries of the 1970-71 official reports. Complete official reports, including that of the auditor, appear in the 1971 Official Reports Book, which is available upon request.

Board of Trustees and Councilors Park M. Horton, M.D.

This report summarizes significant actions taken by the Board of Trustees during the 1970-71 year, as outlined in the board's annual report.

The board:

Approved the Articles of Incorporation of the Pennsylvania Medical Care Foundation. Also authorized the Council on Medical Service to apply for federal funds to initiate an experimental peer review project. Peer review is a major part of the proposed foundation plan which will be presented to the members at a special reference committee hearing in the afternoon on Tuesday, October 5, 1971, during the Annual Session at the Pittsburgh Hilton Hotel;

Approved the proposal for a group professional liability program submitted by Argonaut Insurance Company and Parker and Company International, Inc. This program is designed to provide the membership with maximum professional liability insurance at the lowest possible cost and features Society participation in all underwriting decisions;

Adopted recommendations designed to alleviate pollution in the Great Lakes;

Approved the white paper on emergency medical services prepared by the Council on Education and Science and published in the June issue of PENNSYLVANIA MEDICINE. The white paper explores the current status of emergency medical services in Pennsylvania and presents thirty-four specific recommendations for the improvement of services;

Determined to hold a special long-range planning meeting of the board on August 12, 1971, in order to set aside current problems and review Society objectives;

Formulated recommendations for action by the House of Delegates which would restructure the Medical Defense Fund to provide legal assistance, upon authorization by the Board of Trustees, in cases which have a broad impact on health care issues and the practice of medicine. As recommended, the criterion for intervention by the fund would no longer be solely because the member had no liability coverage (since the Society now offers a group liability plan); use of the fund would be limited to resolution of major issues affecting a broad spectrum of the membership;

Determined to continue as grantee for the Susquehanna Valley Regional Medical Program;

Met with the deans of the Pennsylvania medical schools, or their representatives, on May 12, 1971, to discuss the production and training of physicians in Pennsylvania, the attendant costs and use of innovative techniques in order to train physicians within as short a time as possible. In view of the value of the meeting, the board plans to schedule further meetings periodically with the deans.

Secretary Raymond C. Grandon, M.D.

The workload of the secretary's office increased this year as a larger number of physicians formed professional associations or professional corporations. As you know, Regulation 11.3 of the State Board of Medical Education and Licensure requires that the names of professional associations and/or corporations be acceptable, from an ethical point of view, to the county medical society in which the principal office is located, the State Society, and the State Board of Medical Education and Licensure. In calendar 1970 we processed a total of thirty-six names for professional associations/corporations. At the time this report is being written, we have processed a total of ninety-four names during the first four months of 1971.

I have administered the Medical Defense Fund and have participated in the work of the Committee on Medical Benevolence.

The 1970 House of Delegates determined to urge all county medical societies to change their by-laws to admit qualified osteopaths to membership. This House action was implemented in a letter which I sent to component societies' secretaries on November 5, 1970.

The secretary's office has referred grievances to county societies and in cooperation with legal counsel has provided legal opinions to members of component societies. It has been a pleasure and a privilege to attend board meetings.

JUDICIAL COUNCIL

In 1970 the House recommended that the Judicial Council henceforth conclude its opinions or reports with a statement indicating the mechanism for appeal. The council has noted this recommendation and plans to implement it on all opinions rendered henceforth.

Resolution 70-15
Definitive Interpretation of Sole Arbiter Principle

In 1970, the House adopted Resolution 70-15: "Definitive Interpretation of 'Sole Arbiter' Principle," the resolved portion of which reads: "Resolved, that the House of Delegates, Pennsylvania Medical Society submit a request to the Judicial Council of the AMA for a more definitive interpretation of the AMA guideline as

it pertains to the area of 'sole arbiter' of the disposition of his professional income."

On November 2, 1970, I wrote to Edwin J. Holman, Esquire, director, medical ethics department, AMA, attaching a copy of Resolution 70-15, and requesting that he bring it to the attention of the AMA Judicial Council at their earliest convenience.

On December 11, 1970, I received the following letter from E.G. Shelley, M.D., chairman, Judicial Council, American Medical Association.

"Dear Dr. Grandon:

The Judicial Council of the American Medical Association considered your letter of November 2 at its recently held meeting. The subject of this letter was "Definitive Interpretation of Sole Arbiter Principle" as adopted October 7, 1970, by the Pennsylvania Medical Society's House of Delegates. The opinion of the Judicial Council of the Pennsylvania Medical Society dated March 26, 1969, established "Guidelines for Hospital Medical Staffs" was also considered.

After review of this material it is the suggestion of the Judicial Council of the American Medical Association that this matter might be clarified by rewriting paragraph 9 of the "Guidelines" as follows:

"9. The physician is the sole arbiter as to ways in which he may dispose of his professional income, consistent with the laws of the land, the Principles of Medical Ethics of the American Medical Association and the Pennsylvania Medical Society and the bylaws of the medical staff and medical societies of which he is a member."

In addition, the paragraph on page 11 of the March 26, 1969, report of the Judicial Council of the Pennsylvania Medical Society commencing with the words "It is important" and ending with the words "of absolute right, relocate" should be deleted.

Sincerely,
E.G. Shelley, M.D."

At a meeting on December 17, 1970, at Society Headquarters, the council voted to amend guideline Number 9 from its opinion dated March 26, 1969, to read as follows:

"The physician is the sole arbiter as to the ways in which he may dispose of his professional income, without duress, consistent with the laws of the land, the principles of medical ethics of the American Medical Association and the Pennsylvania Medical Society, and the By-laws of the medical staff and county medical society of which he is a member."

The council also voted to delete the following paragraph from its opinion of March 26, 1969:

"It is important also to remember that your Council continues to recognize (see guideline number 9) that the physician is, in the final analysis, 'the sole arbiter of his income,' for, if a physician is unwilling to support such a fund when same is established by a majority vote of the medical staff, he can, as a matter of absolute right, relocate."

A complete copy of the amended opinion is available from Society headquarters.

On December 17, 1970, the council met to consider a matter raised by a member of the Lebanon County Medical Society with regard to his appointment to the hospital staff of the Milton S. Hershey Medical Center. Final disposition of the case cannot be accomplished until after review of the by-laws of the medical staff of the center. The by-laws to govern the medical staff of the center had been written in January, 1971, but could not be exposed to formal review by the Judicial Council before they had come under the approval of the trustees of the Pennsylvania State University. Up to June, 1971, the proposed by-laws had not been submitted to the Judicial Council for the review necessary to the council's final adjudication.

The 1970 House of Delegates authorized publication in PENNSYLVANIA MEDICINE of the Judicial Council guidelines concerning the ethical storage and retrieval of privileged medical information in computers and distribution of the same to the secretary of each county medical society.

Publication of the guidelines occurred in the December issue of PENNSYLVANIA MEDICINE and county society secretaries were apprised through a letter dated December 21, 1970.

MEDICAL DEFENSE

During 1970 no applications for Medical Defense were filed. The total expenditure for legal fees from the Medical Defense Fund in 1970 was $14,806, leaving a balance of $107,111 in the fund. For further comments on the fund status, see the report of the treasurer.

As of May 31, 1971, there were 11 active medical defense cases in our files. By councilor districts, they are as follows:

First District	2
Second District	3
Fifth District	1
Tenth District	5

Executive Director John F. Rineman

This report summarizes significant points contained in the annual report of the Executive Director:

Actions taken by the 1970 House of Delegates have been implemented or are now in the process of completion.

At a time when several major new Society programs have been initiated, the number of employees paid directly out of Society funds has increased by only one in the past year. Staff presently numbers thirty-nine, about the same in number— although not in responsibility— that the Society has utilized for the past decade. The number of staff assigned to the Susquehanna Valley Regional Medical Program, whose salaries are paid from federal grant funds, decreased slightly in the past year and now totals twenty.

Following the 1970 Annual Session, the membership and staff were staggered by the death of Carl B. Lechner, M.D., long-time Medical Editor of PENNSYLVANIA MEDICINE.

)r. Lechner worked closely with staff and was a beloved riend of the physicians and staff alike.

During the past year a valuable member of the staff re- ired after eleven years of service— Sam C. Price, staff as- istant to the Council on Education and Science. His loyalty nd conscientiousness will long be appreciated and remem- ered by his many friends on the staff and among the mem- ership.

The headquarters building continues to be maintained in xcellent condition. Many of the members and their wives vho have visited it during the past year have mentioned ow fresh and new the building looks despite the fact that it s now five years old.

This year I again held a management conference of key taff at a location away from the distractions of the office. Our focus was twofold— an examination of current man- gement systems with a view to improving them and a col- ective long-range look at our administrative responsibilities nd options.

I feel very keenly that such management conferences, ivorced from the everyday work environment, stimulate alents in our key people which might otherwise not be tilized. In these meetings they are given the opportunity to abandon their parochial responsibilities for a day and con- centrate on answering the question of how the total ad- ministration of the Society can be improved to meet the challenges of new responsibilities.

The Susquehanna Valley Regional Medical Program budget for 1971-72 is $625,710 and includes the cost of operating a program of six projects.

Regional Medical Programs throughout the country were subjected to a minimum of a 12 percent cut in funds for the federal fiscal year beginning July 1, 1971. As a result, sharp cuts in the SVRMP budget were made.

Since September 1970, the program has been housed in the Fernwood Office Building some three miles south of the PMS headquarters office.

The Society prepared 1971 dues statements for fifty-eight county medical societies through Electronic Data As- sociates, the Society's computer service bureau. The only expense to county socieites was postage; supplies and envelopes were furnished by the Society.

There was a decrease of 187 in full dues paying members and an increase of 138 in senior members. In the overall membership, there was a decrease of 83 members.

The Board of Trustees appointed David A. Smith, M.D., of Harrisburg to fill the position of medical editor for PENNSYLVANIA MEDICINE, a vacancy created by the death of Carl B. Lechner, M.D., who served in this capacity with great distinction for many years.

Reprint orders and requests to include articles in anthologies of scientific papers continue to be a source of satisfaction— and a proof of the worth of PENNSYLVANIA MEDICINE'S scientific content.

By strict curtailment of expenses, PENNSYLVANIA MEDICINE was published in 1970 without a budget deficit, despite the fact that nearly half the budget was exhausted in the first quarter. Although the budget established for 1971 offered only a minor increase, expenses have remained well within budget limitations.

By having type set by the phototypesetting method, and by developing page-saving techniques, PENNSYLVANIA MEDICINE is presenting as much scientific material as ever, and more socioeconomic and Society news than ever, in an attractive format. Although income shows little sign of appreciable increase, costs have begun to climb, and indications are that more cost increases are on the way.

I believe the Pennsylvania Medical Society is in the process of a creative transmutation in purpose and design and I know I speak for all the staff when I say we are delighted to be part of it.

Treasurer John F. Rineman

The customary examination of the Society's accounts as of December 31, 1970, was performed by Main, Lafrentz & Co., certified public accountants, and the report of their audit is being submitted to all members of the House of Delegates. It is available to others upon request.

The Society's resources are contained in five separate funds. Four of these funds are earmarked for special purposes and are not available for current operating expenses.

The annual assessment of our members who pay full dues was $75 for the year 1970. Of this total, however, only $65 was available to the General Fund for the operating expenses of the Society. By action of the House of Delegates, $9 per member was allocated as follows: $8.00 to the Educational and Scientific Trust for loans and scholarships and $1.00 to the Medical Benevolence Fund. In addition, the Board of Trustees found it necessary to make a $1.00 per member appropriation to the Medical Defense Fund in order to meet the obligations of the fund for 1970.

The General Fund is the active functioning account for the day-to-day operation of the Society's various programs. During 1970, income for this account (derived chiefly from dues, advertising in Pennsylvania Medicine, commercial exhibits and registration fees at the scientific session, and investments) amounted to $990,989. Expenses for 1970 totaled $912,610. With income of $990,989 and expenditures of $912,610, as well as payments on the mortgage principal and for equipment of $8,951, the Society ended the year with a surplus of $69,428 in the General Fund.

The Medical Defense Fund had assets totaling $106,883 at the beginning of the fiscal year. The appropriation from dues amounted to $10,256 and income on savings and securities of $5,180 provided total income to the fund of $15,436. The fund paid out $14,806 for medical defense purposes and $402 for other expenses for a total of $15,208 which resulted in a gain of $228 for the year, thus increasing the assets of the fund to $107,111 as of December 31, 1970.

Assets in the Medical Benevolence Fund totaled $560,139 on January 1, 1970. The fund received $10,542 from dues allocations and $24,131 from income on investments. Contributions from the Woman's Auxiliary and other sources amounted to $8,059. Loss on the sale of in-

vestments of $11,397 reduced total income to the fund to $31,335. Payments to recipients of $41,665 and investment expense of $2,078 reduced the total assets of the Medical Benevolence Fund to $547,731 as of December 31, 1970.

At the beginning of 1970, the Contingency Reserve Fund was valued at $201,077. The Board of Trustees authorized the transfer of the 1969 surplus totaling $129,720 to the Contingency Reserve Fund. Income on investments was $11,957. Loss on the sale of investments amounted to $707 and investment expenses totaled $965. These transactions resulted in an increase in the assets of the fund to a total of $341,082 on December 31, 1970. On January 6, 1971, the Board of Trustees took action to transfer the 1970 surplus to the Contingency Reserve Fund with the stipulation that the Finance Committee be authorized to invade the fund if funds were required to meet obligations in 1971.

As of December 31, 1970, the Property and Equipment Fund included land and building with a net value of $728,308 and furniture and equipment with a net value of $59,915. Depreciation reserves for replacement of both the building and the furniture and equipment accounted for $149,560. The mortgage was reduced to $82,120 by the end of 1970. The total value of the Property and Equipment Fund (including accumulated depreciation) was $937,783 at the end of fiscal year 1970.

Reports of District Trustees and Councilors

First District A. Reynolds Crane, M.D.

Theodore Roosevelt is credited with saying, "Every man owes part of his life to the profession of which he is part" and each year as this report is prepared one is impressed by the number of members of the Philadelphia County Medical Society (the First Councilor District) who are involved and who care enough about the future to do something about it. Jonathan Rhoads, M.D., the immediate past president, pointed out that more than one of every four members of the Society has been involved as an officer, board or committee member during his term of office. One of the rewards of serving as trustee and councilor is the rereading of the year's issues of *Philadelphia Medicine*, itemizing the accomplishments recorded therein and getting lost in the fascinating blend of local, state and national affairs so ably assembled by the editor, Donald C. Geist, M.D., and supported by the Publications Committee under Alma D. Morani, M.D. One of the chores of being trustee is to try to assemble from the recordings of so many activities a brief sequential report for the House of Delegates and in so doing recommend the reading of *Philadelphia Medicine*. Its contents are both informative and useful.

Leadership of the society has passed from Jonathan Rhoads, M.D., whose firm and practical approach to issues permitted steady progress, to the hands of George A. Hahn, M.D., who, in his installation address, has called for a cooperative effort on the part of physicians and all persons involved in the delivery of health care to meet the health needs of the nation.

The branch societies continue to be an effective instrument in promoting participation in the affairs of medicine and their representation on the Board of Directors is a helpful avenue of communication and understanding in a large and complex society. In the effort to engender cooperation, a Deans Committee under Dr. Eugene P. Pendergrass, M.D., has held several productive meetings devoting much consideration to means of delivering care to underprivileged areas, possibly through county society or branch sponsored clinics suggested by John McClenahan, M.D.

The Professional Relations Committee under Drs. G.F. Tucker and H.S. Wieder, while continuing to evaluate complaints initiated by patients, has raised the question of the society's responsibility to a more active role in the evaluation of the quality of the health care delivered and will pursue this concept (peer review) along with the Board of Censors (R.R. Ravdin, M.D.) and the Insurance Review Committee (J.A. Tucker, M.D.).

The Committee on Membership and Society Organization, under Robert Pressman, M.D., has continued the fine work done under David Cristol, M.D. The society now has a total of 3,765 members of which 2,889 are active members, 413 are associates and 463 are affiliate. The way has been opened for acceptance of osteopaths and a number of applications have been processed. Further revision of by-laws will make interns and residents eligible for active membership.

The awards given this year met with universal acclaim. David A. Cooper, M.D., past-president, former member of the PMS House of Delegates, distinguished physician, and revered teacher, was given the Strittmater Award, appropriately accepted for him in absentia by Esmond Long, M.D., since the two men had done so much to further the understanding of pulmonary diseases. Illness prevented Dr. Cooper's attendance and he died shortly after the award was given. The Benjamin Rush Awards were given to Frank G. Harrington, M.D., for his contributions to the rehabilitation of the handicapped and to Wheels, Inc., for their recruitment and dispatching service in the same field. Eugene P. Pendergrass, M.D., was the recipient of the Distinguished Service Award of the State Society. The DaCosta Oration was delivered by Dr. S.J. Dudrick on "Long Term Total Parenteral Nutrition".

The Committee on Medical Education (S.H. Lorber, M.D.) has been most effective in pursuing means of continuing education and determining educational goals. A self-evaluation program (E.H. Mc Gehee, M.D.) has been implemented and is being expanded to the membership of other societies. A joint meeting with the Institute of Electric and Electronic Engineers on "Engineering in Medicine and Biology" has been sponsored. An interesting and important activity, particularly in view of the recent regulations promulgated by the Welfare Department, is that of a reconstituted Utilization Committee, under G.R. Fisher, M.D., and comprised of members of hospital utilization committees from the city and neighboring areas. This group

hopes to coordinate its efforts with third party payment reviewers, state utilization auditors and government bodies and is compiling a handbook of guidelines for utilization review.

Activities in experimental delivery systems for health care sponsored by Temple University in North Philadelphia and by Pennsylvania Hospital in South Philadelphia (South Philadelphia Health Action) have been closely followed by the society through the Committee on Medical Economics with J.D. Alexander, M.D., as its chairman and with P. Ingaglio, M.D., serving on the Board. Dr. Alexander also serves as a representative of the Society to Group Health Planning of Greater Philadelphia, and with participation in the planning phase of an extremely broad program to coordinate existing facilities in a pre-paid total care program. William F. Bouzarth, M.D., has continued his fine work in emergency medical care and disaster medicine.

A joint task force, representing Blue Cross, the Delaware Valley Hospital Council, and the society, prepared an admirable review of the problem of hospital costs and their containment. This report appears in detail in the February issue of Philadelphia Medicine. J.V. Blady, M.D., is to be commended for this accomplishment.

The woman's auxiliary, under Mrs. Peter Herbut and Mrs. Richard Brunner, has continued its activities on behalf of the society. The Annual Health Institute, devoted to medical education, was an outstanding success. Their fund-raising activities in the interest of nursing education have continued and in addition, Mrs. Brunner in behalf of the auxiliary, presented Dr. Hahn with a check for $500 toward the support of Project Hope in which he and many members of the society have been active.

These are but a few highlights of the activities and only a few of the many dedicated physicians are named. First Councilor District is outstanding as a center of medical innovation, education and progress because of all the activity and all of the active individuals.

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Second District LeRoy A. Gehris, M.D.

The six county medical societies in the Second Councilor District have had a very active year. All of the societies conducted regular meetings. The meetings covered all aspects of health care in the community. Socio-economic and scientific programs were presented. In some instances a recognized leader in government spoke to county societies and groups of county societies. National and state medical leaders also have spoken to county medical societies of the Second District.

In addition to the regular meetings, numerous other activities were conducted by the various county medical societies, such as mass immunization programs against communicable disease, diabetic detection, and glaucoma detection programs. One society presented a certificate of commendation to a steel mill for installing equipment costing over a million dollars to prevent air pollution. Rush Awards were presented and served as a source of good public relations.

One county medical society regularly receives a report of the president of the county woman's auxiliary at the regular meetings of the county society Board of Trustees.

William A. Limberger, M.D., president of the Pennsylvania Medical Society, spoke to each county of the second district on at least one occasion.

Five of the six county medical societies have executive secretarial service. The one county of the district without an executive director is served by a dedicated physician secretary with paid secretarial assistance.

Third District Ralph K. Shields, M.D.

Each county society has either been or will have been visited by me before the annual meeting of the House of Delegates in October, 1971.

On April 17, 1971, our annual Councilor District meeting was held at the Buck Hill Inn, Buck Hill Falls. Representation from each county medical society except one was present. In addition, we were honored to have PMS President William A. Limberger, M.D., with us. Also in attendance were several members of our very capable PMS staff. The theme of our discussion was "Health Care— Five Years from Now". There was interesting dialogue and we all benefited from this experience. Our wives, also in attendance, joined in a pleasant social hour and dinner.

With the thought of making the annual report more meaningful, a questionnaire was sent to the president of each component county medical society in the Third Councilor District. These eight questions were asked:

1. What have been the chief activities and outstanding events in your county medical society this past year?
2. What has your county medical society planned for the balance of this year?
3. What are some of the problems with which your county medical society is faced?
4. What do you feel is the consensus of your membership regarding the State Society?
5. Would your officers and your membership be interested in having a summary of the transactions of each Pennsylvania Medical Society Board of Trustees meeting sent to you by your district councilor?
6. In what ways would you like to see your district councilor provide a more meaningful liaison between the State Society and the component county medical societies?
7. What suggestions would you and your membership offer to improve the effectiveness of organized medicine in terms of health care delivery, government involvement, and costs of health care?
8. Have you any other thoughts which might be helpful to others in organized medicine?

Clearly, from the substance of the various reports, there is a desire for improved communication between the State Society and the county societies in the Third Councilor District. There is a need to do something about this in order that the membership may have greater participation and voice in the decision and policy making. There are good and constructive criticisms in these reports.

In summary I would emphasize that healthy concerns exist in the county societies which deserve and need our attention, at all levels of organized medicine. I would recommend that ways and means be worked out to help bridge the communi-

cation gap which exists. I personally plan to report to each county society the highlights of each Board of Trustees meeting. I believe that more frequent visits to the county societies by officers and staff members of the PMS should be planned.

Fourth District George A. Rowland, M.D.

County society activity has continued at an even pace. Regular scientific programs of high quality have been the rule of all components.

As in the past, Montour County has been meeting in conjunction with Geisinger Hospital staff meetings. Schuylkill County meets at the time of Jefferson Medical College seminars in Pottsville. Schuylkill and Northumberland Counties continue to hold meetings only in the spring and fall avoiding unfavorable weather. Northumberland and Columbia report no difficulty in getting speakers of good quality, even from more distant medical centers. These two societies have held several joint meetings. Pharmaceutical houses have been most generous in offering assistance both in financial form and in the mechanics of obtaining speakers.

Even more than in the past, the biggest problem faced by all of these societies has been member apathy. If doctors are induced by the promise of good meals or interesting speakers to attend a meeting, they either fall asleep or quietly slip out when the business meeting starts. This carried through to the onerous tasks concerned with society officers. It is often necessary to beg members to serve. Really active committee chairmen are almost unheard of. This is a problem that today faces most medical organizations. It deserves study and serious effort to find a solution.

A meeting of representative leaders of all district societies was held at Elysburg in May. There were presentations by members of the PMS staff on the new state medical liability insurance and on the proposed Medical Care Foundation. Interest was high, questions were plentiful, and discussions were heated. These highly interested members of each society are deeply concerned about the problems faced by medicine.

The proposal to establish a district executive office was again presented with little reaction expected. On the contrary, the matter received unlooked for support. It was decided to discuss this matter again later in the year.

Perhaps the most valuable outcome of the more frequent district meetings that have been held in the last few years is the feeling of rapport that has developed between leaders of the different societies. Medical groups that in the past have been as diverse as if they had no common language have begun to speak to each other and recognize common ground. If somewhere a spark can be found to ignite the bulk of the membership the future of these organizations will be assured.

Fifth District David S. Masland, M.D.

The component societies of the Fifth Councilor District have been engaged in their individual projects. I am happy to report that we had excellent representation from this District at the 1971 Officers' Conference.

Adams County

The Adams County Medical Society reports that it has continuing education in progress through the PMS Council on Education and Science. Attendance at these meetings was reasonably good for the first year. Harold O. Clossen, M.D., secretary, reports that the younger physicians in the area have been called on to provide programs for the county society. This has been a fruitful experience for both the society and the speakers.

Cumberland County

H. Robert Davis, M.D., secretary of the Cumberland County Society, reports that the society again sponsored the Athletic Injuries Conference at Dickinson College. This was attended by over 100 participants from most of the schools in the area. The society also sponsored the pre-medical dinner, attended by eighty-five students from Dickinson, Messiah, Shippensburg State, Gettysburg, Harrisburg Area Community College, and Penn State Campus at Middletown.

Dauphin County

The Dauphin County Medical Society reports that since the last meeting of the House of Delegates, the society held its second planning committee meeting at Hershey Motor Lodge for the purpose of exploring the foundation for medical care concept of delivering and financing medical care in Dauphin County. As a result of the meeting, the society sponsored a seminar on the foundation approach in conjunction with the Central Pennsylvania Academy of Medicine at its November meeting. Participants included Russell Roth, M.D., speaker of the AMA House of Delegates and Donald Harrington, M.D., medical director, San Joaquin Foundation for Medical Care. Since then, the society's secretary and executive secretary have attended the Regional Conference on Foundations for Medical Care held in Rochester, New York, April 16 to 18, 1971. It is quite possible the society will form a foundation in the future for the purpose not only of delivering and financing medical care but also for researching socio-economic programs, and serving as a health maintenance organization and peer review organization, if legislation is passed in these areas, as well as conducting mass immunization programs for the citizens.

Another development of the society last year was the appointment of an ad hoc committee to review the health needs of Dauphin County. As yet, no formal report has been made by the committee but it is undergoing a study of such needs and a report is planned for the third planning committee session of the society to be held in August 1971.

The society, through its Committee on Emergency Medical Care and Disaster program has continued to participate in the Harrisburg Area Disaster Planning Council and presently the chairman of the society's committee serves as chairman of the council. Meetings on aircraft disasters, legal aspects of disasters and similar subjects have been presented to representatives of the city and state governments, ambulance, fire and other organizations. In addition the society has agreed that the Committee on Emergency Care and Disaster should explore the ambulance situation

the greater Harrisburg area and report on its present tus at a future meeting.

"Compulsory Health Insurance in the 1970's" was the le of a presentation given before members of the Dauphin ounty Society on February 2, 1971, at the Penn Harris otor Inn. On May 11, 1971, a presentation on "The Hostal and the Physician in the 1970's" was given by Mr. ilton Appleyard, executive director of Harrisburg Hospil, for the benefit of members and wives.

Dauphin County, through volunteer physicians, again rovided free physical exams for 150 or more children who tended the summer camp of the Police Athletic League of arrisburg. In addition, the members participated in the MCA camper program by providing similar examinations r their campers.

The society is participating in the Pennsylvania Medical ociety's Regional Blue Cross Blue Shield— Major Medical rogram which was put into effect January 1, 1971 for the enefit of its members. The society continues to support the tudent AMA chapter located in Hershey and also contribted $50 to SAMA in order to continue its sustaining membership. The society changed its bylaws this past year and ow osteopathic physicians who meet the qualifications of he society are eligible for membership. Liaison with the Bar and Nurses Associations has been continued and the soiety once again participated in the Tri-County United Fund Campaign.

Franklin County

The Franklin County Medical Society has enjoyed an active year. Ten dinner meetings were held throughout the year. Attendance averaged 40 percent of the active membership. Excellent guest speakers covered a wide variety of topics of medical and community health interest. Of note is that in December, the president of the Pennsylvania Medical Society, William A. Limberger, M.D. was the Society's guest.

A very successful rubella immunization program was carried out by Franklin County in November.

The society added its support to Imwalle Foundation, a center for the care and rehabilitation of alcoholics and supported and participated in an Emergency Ambulance Training Course. Society representatives have participated in several meetings aimed at improving communications within the society. Discussions will continue to explore the possibility of sharing an executive secretary.

Lancaster County

The Lancaster County Medical Society stressed community service in 1970-71. William Atlee, M.D., president-elect, worked with the Community Council for Comprehensive Health Planning in order to efficiently coordinate the efforts of concerned health groups. The Emergency Call System of the Lancaster area was revised. Student winners of the science fairs again were exhibited for the society and accepted Savings Bond prizes. The United Fund Campaign was boosted by the film "Be Prepared."

Detective Luther Henry spoke on drug abuse and the executive director of the Human Relations Urban League prodded with "Apathy and Inaction— A Danger to Our Community". The District Nurses Association presented "The Development and Design of the Nurses Role in the 1970's." William LaMotte, Chairman of the AMA Council on Legislation spoke about "Health and Federal Legislation".

Fewer county society meetings have been devoted to scientific topics since hospital-oriented sessions have provided such good coverage. However, Albert Brest, M.D., professor of medicine at Jefferson Medical College discussed coronary disorders and Leroy Shear, M.D. of Temple added to our knowledge of renal transplants and dialysis.

The society named a representative to work with the Explorer Club in offering leadership to youth with science interests. The first doctor of Osteopathy accepted membership in the Society.

Plans are now underway to revise again the bylaws of the Lancaster County Medical Society to make possible membership of residents, interns and students of medicine.

Perry County

The Perry County Medical Society is still discussing plans for a medical care unit to be built in that area. There are now seven medical doctors in the county, one of whom limits his practice solely to obstetrics and gynecology, and five osteopathic physicians.

York County

The York County Medical Society enjoyed a fairly active year in 1970-71. Through collaboration with the auxiliary, meetings on drug abuse were continued, to coincide with programs on Channel 33. Many discussions were held concerning comprehensive health planning. A representative of the Society is playing an active role in the York Community Planning Council. The scholarship program continues to support county residents in medical and paramedical training. Through the medical-legal liaison committee, discussions were held with lawyers and members of the osteopathic society concerning mutual interests and improved relationships.

A composite group picture of society members was taken. Twenty-six past presidents were honored at the Presidential Ball in February. The Society toured the PMS facilities in April.

With the assistance of the PMS staff, they have embarked on a three-year schedule of programs and speakers to culminate in the celebration of the Society's 100th anniversary in 1973.

Sixth District H. Thompson Dale, M.D.

This year my report has some disappointments. The Finance Committee of the Board of Trustees of the State Medical Society refused to provide money to entertain students who are in the last year of premedical education at Juniata College and Penn State University (the schools of higher education in our Councilor District). I appealed to the Huntingdon and Centre County Medical Societies to entertain these students. I heard nothing from the Huntingdon County Society and the Centre County Society refused to request the Centre County Medical Society Foundation to provide funds for students' entertainment.

Funds were available for a district councilor meeting but

since each county society was graciously offered a visit from President William A. Limberger and a representative from our Lemoyne office, I decided to *save the money*. All of our county societies but one were visited by Dr. Limberger this past year.

Blair County

In January 1971 Mrs. Dale and I attended the annual dinner-dance and installation of officers at the Penn Alto Motor Hotel in Altoona. Dr. and Mrs. Limberger, our energetic and capable State Society president and his wife, were honored guests at this meeting. Five members of the Blair County Society offered to do work at the State Society level.

Centre County

The Centre County Medical Society had its usual nine meetings this past year. One of the most outstanding meetings was the one at which Dr. Ford Clark of Huntingdon presented an illustrated talk on some of the experiences he has had on the ship HOPE.

Sunday, June 6, 1971, the annual physicians, dentists and druggists picnic was held at Mountain Acres Camp in the Seven Mountains. This year the lawyers were invited and a total of 125 people attended this excellent affair.

The new State College Mountain View Hospital branch of the Centre County Hospital is behind schedule and may not be finished in 1971.

On April 15, 1971, we were honored to have Dr. William Limberger and Mr. John Rineman, our executive director, speak to this county society and the woman's auxiliary.

Clearfield County

An attempt was made to have Dr. Limberger, State Society president, meet with this society without success.

The former secretary of this society, Dr. Robert Boron, was visiting the Centre County Hospital in Bellefonte in December 1970 and I had a nice visit with him. He was quite concerned about the chiropractic problems in Clearfield. I told him I would be glad to arrange a meeting with our health legislation people from the Lemoyne office and the Clearfield Society but have heard nothing.

I feel disappointed that this fine group of physicians has not taken advantage of the help that the State Society has to offer them.

Huntingdon County

On Tuesday, May 25, 1971, it was my privilege to attend a dinner meeting of this Society. Dr. Limberger and Mr. LeRoy Erickson of our Lemoyne office explained to the 50 percent of the society who attended what the Pennsylvania Medical Society has to offer and plans for the future.

Dr. William Stewart, secretary of this society, Dr. Ford Clark, and ever-faithful Dr. William B. West helped make this a very successful meeting. I hope they can keep up the good work.

Mifflin-Juniata County

Again this year in January, Mrs. Dale and I attended the annual dinner-dance and installation of officers of this active society at the Green Gables Hotel in Lewistown.

I have been informed that State President Limberger, and Mr. Dane Wert, State Society director of communications, attended a meeting of this society in May 1971. I know they gave them very worthwhile information.

Visit to Clinton County

On Saturday evening, June 12, 1971, Mrs. Dale and I were guests of the Clinton County Society at which President Limberger and Mr. Rineman addressed the society. About 75 percent of the society members and their wives attended this fine meeting. The Seventh District Councilor, Dr. Robert Sanford, and his wife were present.

I am anxious to hear from any of our members and anxious to help try to solve any problems that may arise in this 6th Councilor District.

Seventh District Robert S. Sanford, M.D.

As Trustee and Councilor of the Seventh Councilor District it has been my pleasure to serve the component county societies of this District during the past year. Although personal visits to the individual county societies were not as frequent as desired, the interests of each county were included in the many discussions and meetings I attended during the last year.

I would like to remind the House of Delegates and the members of the Seventh Councilor District that the practice of medicine is undergoing a revolution brought about by the overwhelming advances in medical knowledge as well as the overwhelming demands being placed on each practicing physician. These demands are creating so great a volume of paper work and non-medical responsibilities that there is less time to concentrate on the actual practice of medicine. Increasing numbers of members of the medical profession are leaving the actual practice of medicine because of the pressures of non-medical responsibilities.

Much time and effort is being expended by the American Medical Association and the Pennsylvania Medical Society to keep the practice of medicine out of government control. The most recent effort on the part of the Pennsylvania Medical Society is the introduction of the Foundation type of health care payment arrangements. It is true that this set-up creates self-discipline by the medical profession in the form of utilization and peer review. More non-medical work is required to make such a program feasible. However, the medical profession must take the initiative in order to maintain its independence. If this is the way to remain independent of government control, this Councilor urges its development.

Except for the Williamsport area of Lycoming County and the Lock Haven area of Clinton County, the Seventh Councilor District is rural in its nature of medical practice. Available hospitals are mostly small in size as are their respective staffs. Such circumstances make peer review, chart review and utilization review too personal a situation to be healthy for good staff relations. Yet, if such disturbing duties are not performed, the entire operation of medical care is jeopardized by the threat of non-payment.

This Councilor would like to see an in-depth study and analysis of medical practice trends in an effort to uncover some solutions to these problems before discouragement conquers.

For the Seventh Councilor District, I am happy to report hat there have been no major problems during the past ear. The participation of the counties in the activities of he Pennsylvania Medical Society has been in general quite atisfactory. All counties within the Seventh District have xpended considerable effort, and experienced excellent articipation in continuing education programs. Physician ecruitment activities are being carried out in the Tioga and lk-Cameron Societies although additional physicians are eeded in all counties.

The coming year should be a busy one for all the counties n providing the required postgraduate programs. This Councilor is anticipating one of the finest years from each component society in his Councilor District.

Eighth District David J. Keck, M.D.

The following is a summary of the activities of some of the county medical societies comprising the Eighth Councilor District.

Crawford County

Crawford County membership has remained the same this year, and as with all counties, is experiencing a shortage of physicians. The members have ten dinner meetings a year at which there have been speakers on scientific or economic topics. In December of this past year, PMS President Limberger and John F. Rineman, PMS executive director, gave an interesting presentation to the members.

The members, in cooperation with the Pennsylvania Department of Health, conducted a rubella vaccination program, which included children from kindergarden through the sixth grade. This was a successful venture.

Crawford County continues to have Pennsylvania Medical Society Continuing Education Programs twice a month. These programs, conducted at Spencer Hospital, have had good attendance.

The Woman's Auxiliary continues to be active and is still in the process of furnishing a room in the Baldwin Reynolds Home Museum with medical artifacts.

Erie County

Listed below are the principle activities indicating a most successful year for Erie County:

1. Disaster drills were held at both hospitals under the direction of William P. Garvey, M.D., in cooperation with the local Civilian Defense Organization.

2. Conferences were held with the United Steelworkers and various senior citizens' groups to discuss current problems.

3. $3,800 in scholarships from the Erie County Sabin Scholarship Fund were awarded to sixteen students.

4. Leonard B. Snider, M.D., worked ardently with the Future Physicians Club to build interest. Meetings were held at Hamot Hospital, with 40 to 50 high school students attending.

5. Centenarian Awards were presented to patients of Robert B. Stuart, M.D. and Charles R. Leone, M.D.

6. A regional medical symposium on group practice in conjunction with the Upper New York Regional Medical Program was sponsored.

7. October 18, 1970 was designated "Rubella Sunday," with 25,000 children immunized against Rubella. This program was held in cooperation with the osteopathic physicians.

8. A Physician Recruitment Committee was organized under the leadership of Robert J. Demuth, M.D., and funds to be used to secure more physicians for the Erie area were budgeted.

9. The Drug Committee, chaired by William P. Garvey, M.D., is working in cooperation with other Erie city agencies to help alleviate the drug abuse problems.

10. A new Speakers' Bureau was developed, with Public Service Chairman A.T. Merski, M.D., providing the necessary leadership.

11. Four membership meetings were held, plus monthly Executive Committee meetings excluding July and August.

12. Four successful golf tournaments were held, including a physician-dentist match, and the bowling team remained active throughout the season.

McKean County

McKean County gained two new members this past year, for a total of thirty. The membership continues to hold ten meetings a year, alternating between Kane and Bradford. Again this year, the annual Christmas Dinner Dance was held at the Penn Hill Country Club.

The society conducted a rubella vaccination program for children from kindergarden through sixth grade, in conjunction with the Pennsylvania Department of Health.

McKean County continues to have good attendance at the Pennsylvania Medical Society's Continuing Medical Education Programs.

Mercer County

The Mercer County Medical Society continued with approximately 96 active members. New members welcomed were Drs. John Tragellis, Jesus Chaves, Jr., and Federico P. Vallesteros.

Meetings were held at the Shenango Inn, Sharon, in the months of October, November, January, April, May and June. In September 1970, the county society, as a group, toured the Mercer County Home and Hospital and were the guests of the hospital for dinner. The tour was informative and many of the members were impressed by the County Home and Hospital.

The Mercer County Medical Society sponsored a lecture on drug abuse by Dr. Bloomquist, of California, in February 1971 to which the dentists, pharmacists and osteopaths, in Mercer County were invited.

Mercer County presented the Individual Benjamin Rush Award at their May meeting to Mrs. Margaret Finucame of Sharon, and the Group Award to the Phi Theta Phi Fraternity from Thiel College, Greenville. The Phi Theta Phi Fraternity is responsible for the Walk-A-Thon in support of the Children's Hospital in Pittsburgh. The Mercer County Medical Society was happy to see that the Greenville Lions Club, last year's Benjamin Rush recipient, won the State Benjamin Rush Award.

Drs. Ricciutti, Biggins, Connelly and Kline attended the Officers' Conference in April 1971.

The Mercer County Medical Society contributed to the

restoration fund for the home of Benjamin Rush in Philadelphia. The society also entertained the Mercer County Dental Society at the June 9, 1971 meeting which was a social occasion. This was part of a continuing effort by the society and the Dental Society to become more familiar with the other's society.

Warren County

The Warren County Medical Society will celebrate its 100th birthday on September 29, 1971. It is interesting to note that the celebration will take place in the same home at which the society was organized 100 years ago. The official celebration includes a reception followed by dinner.

The membership continues to meet ten times a year with meetings held on the third Tuesday of the month. Followed by dinner and discussion of various interesting topics, these meetings take place at Warren State Hospital.

A rubella program was conducted this past year with children from kindergarden to the sixth grade immunized.

Pennsylvania Medical Care Foundation

Special Reference Committee on Medical Service "B" will consider the Supplemental Report on the Medical Care Foundation at 1:30 p.m., Tuesday, October 5, 1971 in Ballroom No. 3. All delegates are urged to attend this reference committee hearing.

Ninth District Cyrus B. Slease, M.D.

The county medical societies of the Ninth District are active and all hold regular meetings. Nearly every meeting has some scientific or academic type program. Attendance is generally good, ranging from 25 percent to 90 percent.

Some county societies are getting programs for meetings through the Regional Medical Program.

Joint meetings of two or more county societies have been held and more are being contemplated.

Clarion County has a visiting nurses association ready to start work July 1, 1971. This project is 100 percent *community* funded.

County visitations are at the halfway point at this date.

The shortage of physicians in every county of the District still exists, and the hospital emergency room practice continues to increase.

The physicians of the Ninth District have in general, been trying to practice good medicine during the past year. This has occurred despite the increasing demands on their time, and more patients are being treated more efficiently and with more success.

It is the opinion of many physicians that comprehensive planning and regional programs are weak and wasteful and should be re-evaluated.

The general feeling is that increasing demands on physicians' time and increasing restrictions on utilization will not only elevate the cost of medical care by necessitating repeated hospitalizations for the patient but will also compound the shortage of physicians.

Since we as a district feel that medical care can be improved we respectfully submit three requests, regarding regional or comprehensive programs.

1. Spend less on administrative costs.
2. Simplify and streamline applications for grants.
3. Plan medical care from the "grass roots" up— rather than from bureaucracy down.

I know these requests cannot be acted upon by the House of Delegates but perhaps they will outline some of the thoughts of the physicians, who try to provide the medical care needed in their respective communities.

Tenth District William J. Kelly, M.D.

Allegheny County

The society's new headquarters building, located on Ridge Avenue in the north side of Pittsburgh, became a center of health affairs in 1971. The headquarters also became a regular meeting place for the Pittsburgh Academy of Medicine, the Southwestern Chapter of the American College of Surgeons, twelve medical specialty societies, the Hospital Planning Association of Allegheny County, the Western Pennsylvania Regional Medical Program, the Health and Welfare Association, the Hospital Utilization Project, the County Medical Society Foundation, medical assistants, medical records librarians, Visiting Nurses Association, and various hospital medical staffs.

The society continuing involvement with approximately thirty hospitals and 2,000 physicians serving an estimated

6 million population in Allegheny County, has generated gnificant activity in health affairs. The Poverty Committee and the Health Services Planning Committee are actively engaged in efforts to improve medical services for the tire county and, through its co-sponsorship of a community council, the society is exerting efforts to obtain a 250,000 grant for emergency medical care which is needed up-grade and coordinate these services. Local political oblems have blocked receipt of these funds although the propriation has been partially approved at the federal vel. The Medical Advisory Committee to the Hospital lanning Association reviewed proposals amounting to approximately 130 million dollars during the past year. The rgest proposal approved would completely replace the lercy Hospital in its present location at an estimated cost f 60 million dollars. The highly controversial concept of regional" hospitals or centers continues to be discussed, as ospitals are keenly interested in determining their roles in elation to such proposals, and local physicians have turned the county medical society for representation in discusion dealing with the proposed regional hospitals and the niversity's health center.

Peer review and utilization committee activity continue be of great interest in Western Pennsylvania. At the equest of the State Society, the county society did not file a roposal for a separate grant but expects to participate as enth Councilor District component under the PMS pplication to the Health, Education, and Welfare Department. The society is also in the process of establishing supplementary committees which would relate to this plan.

Membership records and physicians' information files have been computerized. Arrangements have been made with the Hospital Utilization Project to provide assisting services and to assist in this work. The society employed a systems analyst holding a degree in education.

Activities of particular significance this year involved continuing education, legislation, public relations, and emergency medical care. Because of the changes in PMS requirements for continuing education, special action was taken and a special continuing education committee appointed. Intern and resident membership has been given study and various meetings will be arranged with local hospital medical directors to better acquaint house staffs with organized medicine. Bylaw changes are being prepared to accomodate these memberships.

At the society's 106th Annual Dinner, AMA President Dr. Walter Bornemeier, was the featured speaker. The Harold B. Gardner Award was presented to Frank B. Clack, director of the Allegheny County Health Department for his devoted efforts to clean up the environment in Pittsburgh. Mrs. Leslie Jay Reese, founder and president of the Twenty-Five Club at Magee Womens Hospital, received the Benjamin Rush Individual Award for her contributions to infant research. The Benjamin Rush Organizational Award was presented to the Pittsburgh Ostomy Society, and the Frederick M. Jacob Physicians Merit Award was presented jointly to Dr. Alexander H. Colwell and to your Tenth District Councilor. A special luncheon, held prior to the annual dinner in honor of Dr. Bornemeier and President Fred Brady, was well attended by educators and civic leaders from various institutions in Western Pennsylvania.

Legislative activity has increased and the Committee on Public Health Legislation has been reorganized. Special attention has been focused on chiropractors and the proposed Drug, Device and Cosmetics Act. A successful legislative dinner was held and Dr. William A. Limberger, president of the Pennsylvania Medical Society, and several members of the executive staff in Harrisburg attended. Mr. Stanley Schaeffer, president of Duquesne Light Company, and chairman of the board of the Hospital Planning Association was guest speaker. Many comments from legislators and others indicate that the impact of the society in the community has been considerable. In cooperation with PMS and the AMA, society officials participated in the annual Congressional Visit. Support for PaMPAC and AMPAC appears to be gradually increasing and their representatives have been invited to society functions on various occasions. A fall meeting for the entire membership on the subject of public health legislation is scheduled at the new Pittsburgh Stadium. The Medical Society and the Bar Association plan to invite the Insurance Commissioner to discuss "no fault" insurance and other issues of interest. Earlier this year more than 200 physicians met at the Stadium Club when the society invited officials of Pennsylvania Blue Shield to discuss changes in the participating agreements. Another special meeting will include a discussion of peer review, the proposed PMS Foundation and group practice.

Several new committees were appointed this year to consider problems involving pollution and drug abuse. These committees were active and held meetings at society headquarters for discussions with representatives of local agencies and the community-at-large. Radio and television programs sponsored by the Public Relations Committee were well received. The Geriatrics and Chronic Disease Committee has made a strong effort in focusing on the upgrading of standards in boarding homes. Membership Committee meetings and orientation dinners were held with new members accepted into the society. Woman's Auxiliary functions held in the new building have been successful and this is a pleasant dividend.

An operational grant enabled the Western Pennsylvania Comprehensive Health Planning Agency to employ a full time staff group to implement the activities in the twelve county area. Medical societies continue to be represented on the Board of Directors and on a recently formed medical advisory committee. Principles for reviewing various proposals and the establishment of proper methods to relate to sub-area groups are being finalized at the time of preparing this report. More communication with practicing physicians is desirable. It would be premature to evaluate the program at this time.

Western Pennsylvania Regional Medical Program is established and continues to make progress. It is the opinion of Allegheny County representatives that the program deserves continued support. The county society and WPRMP co-sponsored a seminar attended by more than 300 health related personnel and physicians on the subject of physicians assistants. Participants included C. Grove McCown, PMS legal counsel, and his comments were appropriate with respect to the concern of organized medicine regarding the legal liability of utilizing assistants. Allegheny County Medical Society conducted a survey on the use of

physician assistants in non-primary practice with a 90 percent response from its membership— a notable achievement and a sign of respect from its membership for this Society. Continuous and up-to-date revisions of this county society's bylaws are being accomplished.

The Allegheny County Medical Society Bulletin with its new format and variable contents continues to be one of the most informative, readable, and most acceptable documents on medicine in this state as well as the county which it serves. This County Society continues as always to be one of the leaders in organized medicine not only in this state but in the country as well. They are interested, they are active, and they are loyal to the true ideals of medicine.

Beaver County

The district censor of the Beaver County Medical Society reports a total membership of 157, of which number 149 are active members, 6 associate members, and 2 in residencies.

Beaver County did not hold a Health-O-Rama in 1970. In its place, a rubella immunization program was held, with a make-up day a month later. An estimated 21,000 children, ages 1 to 12, were immunized against this disease.

The September meeting was combined with the Woman's Auxiliary and held at the Country Club. Russell B. Roth, M.D., Erie, speaker of the AMA House of Delegates presented his cartoon talk entitled "What's so Funny about Practicing Medicine?"

In December the Beaver County Medical Society again entertained the medical students residing in Beaver County at a dinner while they were home on vacation. The members, together with hospital administrators, are doing their best to try to influence some of these students to return to Beaver County to start their practice of medicine.

J. Willard Smith, M.D., was honored in January for thirty-one years of service as secretary-treasurer of the society. A nursing scholarship in the amount of $500 has been established at Beaver County Community College for a deserving nursing student residing in Beaver County. It will be known as the "J. Willard Smith, M.D. Scholarship". It is recommended that future boards of the society will carry on this scholarship. Ruth Wilson, M.D. received the PMS Fifty-Year Award at the same meeting.

The Program Committee for 1970 did an excellent job in obtaining speakers for their scientific meetings. The attendance is still above average.

In March, an alcohol and drug abuse seminar was held at the Rochester General Hospital sponsored by the county medical society, Beaver County Pharmaceutical Association, Beaver County Drug Commission and the Beaver County Commissioners. Outstanding speakers from the Pittsburgh area spoke to the physicians, pharmacists and nurses in attendance.

Dr. William Gillespy, representative to the Pennsylvania Comprehensive Health Planning, reported to the society the appointment of a new executive director. He stated that meetings were to be held more frequently than the previous quarterly schedule. Within each county there is now a chairman of the representatives to the sub-area council; Mr. Wilbur Fisher is the acting chairman for Beaver County. This society's members were also very active and influential in the local political arena this past year. Through their own personal contributions and their efforts in procuring PaMPAC support, they were successful in supporting candidates favorable to their local programs and medicine's goals. This society continues to support a lay member from their area on the PMS Advisory Committee.

The society was quite active in the Beaver County Joint Hospital Planning Association. They have three representatives on the Medical Advisory Committee.

Membership and officers of this society were very active in their participation on State Society commissions and committees this past year and are to be congratulated and thanked for their devotion to the State Society. They are organized and active.

Lawrence County

The Lawrence County Medical Society has met monthly except for the summer months. The Board of Directors have met regularly throughout the year, at which time routine business was transacted. There was a social function in June and also in December for members and wives of the Lawrence County Medical Society. No special projects were undertaken during the year. Efforts are still being made to have more active participation in comprehensive health planning at the local level. The Comprehensive Health Planning Agency has recently invited members of this society to be involved in their clinics and participate in their meetings. Members of this society were personally very active in their opposition to the chiropractic bill and personally made their legislators know medicine's viewpoint as well as their own on this issue. It is also worthy to note that in the hospitals in this area physicians were successful in being placed on hospital boards. This is a direct reflection of the pursuit and ability of this county society's membership.

Officers of this society continue to attend the State Society's meetings and participate in its committee activities.

The Lawrence County Medical Society, though small and located in a highly competitive and poorly distributed area, geographically, continues to assert itself on the ideals of the practice of medicine and the goals of organized medicine. I commend them for their efforts, as it has not been easy.

Westmoreland County

The society's membership of December 31, 1970, was 224-216 active members, 3 temporary associate members, 6 associate active members, and 19 permanent members. There were 4 deceased members in 1970.

Ten excellent meetings were held through the year climaxed by the annual May Clinic held at Greensburg Country Club and the combined meeting with the Indiana County Medical Society and auxiliaries at Torrance State Hospital. Attendance at these meetings was above average.

The society has had excellent scientific meetings for its membership throughout the year. Also it has been very active in participating in and replying to community projects and requests.

The auxiliary entertained the society at a dinner dance at the Greensburg Country Club and also at dinner at the Latrobe Country Club on Doctor's Day.

The Westmoreland County Medical Society Scholarship Fund renewed four scholarships and awarded two new ones

r 1971-72. The County Society Bulletin continues to do superb job of notifying its members of meetings, oblems, membership, and activities of this devoted group.

In the opinion of the councilor, its officers have done an cellent job of keeping abreast of and participating in State ciety activities.

In summary, may I state that I have tried to keep the cieties in the Tenth Councilor District informed by nding them summaries of all the PMS Board of Trustees eetings. It truly has been a pleasure and an educational perience to have been associated with these Tenth Coun- lor District county societies and their members this past ar.

leventh District William C. Ryan, M.D.

In serving as District Trustee and Councilor for the past ear, I have found it very difficult to adequately fill the shoes f the late Dr. George Bloom whose unexpired term I have een privileged to fill. The year was spent becoming cquainted with the characteristics and problems of compo- ent societies, in an effort to better understand the role of the ennsylvania Medical Society.

All component societies of the district held regular meet- ngs throughout the year, and each society has been active in he affairs of its local community. Meetings were held with he officers and/or board of trustees of each component soci- ty.

Each county continues to have problems in identifying ommon goals which will serve as a focus of involvement for ll members in its area. Physicians do not seem to look to the ounty society for professional leadership and often view the tate Society as a political third party in the practice of medi- ine. Characteristically, it is quite difficult for physicians to eparate the decision making process used in patient care rom that applied to professional education and socio-poli- ical areas. County societies, in general, do not clearly under- tand the philosophy of the PaMPAC organization. There is tendency on the part of many physicians to assume that PaMPAC is, or should be, identified with one or the other of he major political parties.

William A. Limberger, M.D. PMS president, and Mr. John F. Rineman, PMS executive director, extended them- selves by accepting invitations for meetings with individual societies of the district in order to communicate more clearly what the State Society means to individual members.

A meeting of officers and delegates of one of the societies was held in September in preparation for the October Annual Session of the House of Delegates.

The year was an educational one for me as I learned some of the fundamentals of State Society operations, and became more familiar with the problems of component societies of the district. I wish to express my thanks to all physicians in the district for the cordial welcome extended to me on my visits. I enjoyed the fullest cooperation as I explored the char- acteristics of the district and learned to think more carefully about the needs of individual members.

Twelfth District Park M. Horton, M.D.

Bradford County

The Bradford County Medical Society has sixty-three active members and six associate, affiliate or senior members, and two members in service. This society holds meetings monthly with excellent scientific programs which are well attended. They held a joint meeting with the Bradford County Bar Association on December 16, 1970, which was an outstanding meeting. The meeting was highlighted by a paper by George W. Corner, Sr., M.D., executive director of the American Philosophical Society in Philadelphia, on the subject, "The Ethical Aspects of Abortion: An Embryologist's View".

The Bradford County Society, this year, changed the beginning of their year from May to January and Paul Shallenberger, M.D. succeeded George W. Corner, Jr., M.D. as president.

The Woman's Auxiliary of the Bradford County Medical Society is very active and usually meets concurrently with the county medical society.

Luzerne County

The Board of Directors of the Luzerne County Medical Society meets the first Wednesday of each month in the Society Building at 130 South Franklin Street, Wilkes-Barre. The regular meetings of the Society are usually held the third Wednesday in the month at one of the hospitals. Among the excellent speakers who appeared before the scientific meetings were: Bertrand M. Winer, M.D., clinical associate in medicine, Harvard Medical School; Thaddeus S. Danowski, M.D., professor of medicine, University of Pittsburgh; and William Dornette, M.D., chief of anesthesiology, Veterans Administration Hospital, Cincinnati, Ohio. These meetings were alternated with socio-economic subjects in combined meetings with dentists, lawyers, and the medical staff of the local veterans administration hospital.

In addition to the regular Board of Directors meetings and the scientific meetings, the Luzerne County Medical Society met with representatives of the Northeastern Pennsylvania Health and Hospital Planning Council, Model Cities Agency, Rural Health, and the Greater Delaware Valley Regional Medical Program. The Society also participated in a TV Drug Abuse Program "Rap-Line" on November 14, 1970. A luncheon meeting with state legislators to discuss chiropractic legislation was held on April 17, 1971.

Questionnaires were mailed to all physicians in the county. From these a physician's profile is being summarized and coded for computer run-off. Information derived will be distributed and presented to all groups planning health care needs for the area.

The annual meeting and formal dinner dance was held at the Hotel Sterling on January 23, 1971. The individual Benjamin Rush Award was presented to Stanley Penkala who has received national recognition for his services to the United Cerebral Palsy program. The group Benjamin Rush Award was presented to the Luzerne Lions Club for services provided to safety patrols, ambulance corps, scout lead-

ers, and for contributions of medical identification bracelets and wheel chairs. Pennsylvania Medical Society Fifty-Year Awards were presented to Drs. George W. Taggart, Lewis Reese, and Wilson C. Marsden. Preceding the dinner, paintings and sculpture by local artists, of doctors and their families were displayed in the exhibition center. The theme of art and medicine was carried over through the table decorations. PMS President William A. Limberger, M.D., was guest speaker at the dinner. The meeting was highlighted by the report of the president, William Pearlman, M.D., and the installation of George B. Davis, M.D., as president for 1971.

The Hazleton Branch of the Luzerne County Medical Society meets monthly at the Hazleton State Hospital. Their programs are both scientific and socio-economic. Eugene LaBuz, M.D., is president and J.J. Coyle, M.D., is the representative to the parent society.

The woman's auxiliary to the parent society and the Hazleton Branch is very active and honored their physician husbands on "Doctor's Day" March 30, 1971.

Susquehanna County

The Susquehanna County Medical Society has fifteen active members with an average attendance at its monthly meetings of about 70 percent of its membership. A new format for the meetings was instituted during the year. The first hour of the meeting is devoted to Society business with a discussion of Legislative Bulletins and AMA Newsletters. This is followed by dinner with many of the members' wives present and dinner is followed by a scientific program and usually an invited guest speaker. This appears to have met with the approval of the members and succeeded in keeping the membership better informed regarding organized medicine's activities. At the annual meeting of the Society Michael Markarian, M.D., succeeded James Grace, M.D., as president for 1971.

Wyoming County

The Wyoming County Medical Society meets every two months. Their meetings are held on a Sunday afternoon and include the ordinary society business, scientific programs and dinner. They have a high percentage of membership attendance at their meetings.

This society has been unusually successful in attracting younger physicians into this largely rural county and also in obtaining their participation in organized medicine.

At the annual meeting of the Society, held in November, 1970, Arthur Sherwood, M.D., was installed as president.

A Twelfth Councilor District meeting was held in the Wood Room of the Host Farm Motel in Lancaster on October 5, 1970. At this meeting various reports to the House of Delegates along with resolutions which had been published were discussed. Three of the four county societies were represented at this meeting. Another Councilor District meeting is being planned for September, 1971.

PMS President Limberger, and members of the PMS staff have attended meetings of three of the county societies in this District on one or more occasions.

The Twelfth Councilor District is involved with three Regional Medical Programs and two Health Planning Councils. Luzerne and Wyoming County Societies are involved with the Greater Delaware Valley Regional Medical Program and the Health and Hospital Planning Council of Northeastern Pennsylvania. Bradford and Susquehanna County Societies come under the service of both the Central New York Regional Medical Program and the Susquehanna Valley Regional Medical Program, while most of their efforts in health planning have been through New York Penn Health Planning Council, Inc., with headquarters in Binghamton, New York. With the efforts of busy physicians being dissipated in so many directions it is little wonder that actual effects of Regional Medical Programs or Health Planning Councils are not very apparent to the Councilor.

Reports of Standing Committees

Advisory Committee to the Woman's Auxiliary

Since no meetings were held during the year, advisement by the Advisory Committee was received by mail.

The chairman reviewed the program and participated in the Annual Mid-Year Conference held April 21-22, 1971. A forum on Alcohol in Relation to Highway Safety was presented during the conference.

From October, 1970, until April 15, 1971, $2,589.27 was contributed to the Auxiliary's Health Careers Financial Aid Fund established in 1970 to provide financial assistance to students who wish to continue their education in the allied health professions.

The expansion of the Health Careers Recruitment Program of the Pennsylvania Medical Society was aided by the auxiliary. To date forty-nine "Careers in Health Clubs" have been established.

The auxiliary continued to emphasize the importance of women's involvement in political action groups by promoting "PaMPAC Membership for Women."

The following auxiliary priority projects for 1971-72 were approbated by the Auxiliary's Board of Directors and the Advisory Committee: American Medical Association Education and Research Foundation, Health Careers, Legislation, Membership, and Publications.

In order to alleviate overlapping, the consolidation of all community health programs was adopted; therefore, Community Health, Children and Youth, Home-Centered Health Care, Mental Health, and Safety-Disaster chairmanships will be replaced by committees on health education concerned with educating the public in such areas as immunization, drug abuse, alcohol, safety, etc. and Volunteer Health Services, responsible for direct service opportunities such as volunteer work in health facilities including vision and hearing testing, homemaker and meals service, etc.

Aid to Education

In the 1970-71 school year, 148 students enrolled in 28 medical schools received $129,125 in loans from the Educational Fund. In addition, loans of $5,165 helped five

hildren of deceased members continue their college education.

The terms of the loans granted from the Educational Fund will be revised beginning with the 1971-72 school year to provide for a forgiveness benefit of interest payments and a deferment of principal repayments for borrowers who remain in Pennsylvania for their internships and residency training.

The Committee on Aid to Education recommends that the $8.00 allotment from the annual assessment of active members for the Educational Fund be continued for 1972.

Constitution and Bylaws

The committee met on March 18, 1971 to consider an Agenda which included referrals from the House, the Board, and correspondence as well as items generated within the committee. Suggested language for all Constitution and By-law revisions is found in the "Official Call."

I. Amended Resolution 70-I: "Expanded Membership of the Judicial Council" -

The Committee on Constitution on By-laws considered this Resolution at length on March 18, as did the Reference Committee in Lancaster. In this year's "Official Call" the committee has submitted amendments which liberalize the qualifications for membership on the Council, without impairing its effectiveness.

Resolution 70-I as amended by the House of Delegates reads:

"RESOLVED, the Committee on Constitution and By-laws be instructed to further investigate the advisability of increasing the number of members of the Judicial Council as well as changing the qualifications necessary for membership and that they bring to this House of Delegates at its next annual meeting an appropriate recommendation for the members of this House."

After soliciting and receiving testimony from a number of individual members and Society components, the committee makes the following recommendations:

(1) The current five-year term on the Judicial Council with a maximum of two consecutive terms should be reduced to a maximum of three, three-year terms. It is hoped that the shorter term (three years) will be acceptable to younger members and mitigate the fact that they must exclude themselves from virtually all other Society activity while serving on the Council. At the same time it allows a man who chooses to serve to remain for a significant period of time.

(2) The Secretary of the Society, who is also Secretary to the Judicial Council, should be made a voting alternate in the event that one of the regular members is absent. Thus, without increasing expenses, the Society has moved to guarantee that the greatest number of votes possible will be cast on any given case. The committee does not believe that a quorum of seven or nine would ipso facto render better decisions than a court of five. Contrarily, a large council would be more unwieldy and more expensive.

(3) The current qualifications for service on the Judicial Council be liberalized in the area of membership in the House of Delegates. The requirement of ten (10) years of service in the House is too restrictive and should be reduced to five (5).

II. Increased Size of and Change in the Procedure of the Committee to Nominate Delegates and Alternates to the AMA -

The 1970 House of Delegates mandated us to enlarge the Committee to Nominate Delegates and Alternates to the AMA to include one representative from each Councilor District and to instruct the committee to nominate more candidates than there are offices to be filled.

We considered this proposal at length and had the benefit of comments from the Board, several past-presidents, the chairman of the delegation and the chairman of the present Nominating Committee. In addition, staff surveyed some key states with large delegations to determine the methods by which they nominate delegates and alternates to the AMA and the effectiveness of those methods.

This input has resulted in an alternate recommendation from the Committee on Constitution and By-laws. We believe:

(1) The Committee to Nominate Delegates and Alternates to the AMA should be enlarged, but not to twelve members. We think a committee of five (5) would democratize without introducing chauvinism and unwarranted expense.

(2) The Committee should be mandated to seek names from the County Societies.

(3) The Committee, after meeting and choosing its slate, should publish its list of nominees in the "Official Call."

(4) Service on this Committee should be limited to two terms of three years each.

III. Reduction in the Size of the Committee on Objectives -

The 1970 House of Delegates referred a recommendation from the Board of Trustees that the Committee on Objectives be reduced to seven members.

Because ultimate responsibility for objectives lies with this House of Delegates and between its meeting with the Board of Trustees and Councilors, we are offering amendments to achieve the following recommendation:

We recommend that the Committee on Objectives be composed of seven members, four from the House of Delegates and three from the Board. Among the four Committee members from the House, one must be either a student, Intern, or Resident Delegate. The Speaker of the House and the Chairman of the Board shall appoint their respective members annually. This Committee will make an annual report to the House of Delegates and between meetings of the House will report to the Board.

COMMITTEE ON DISCIPLINE SURVEY

Grievance and Disciplinary Actions - 1970

County	No. of Grievances	Committee Action	Cases Closed	Avg. time to close case	Freq. of Committee Meetings	No. of Disc. Proceed.	Break-down	Co. Soc. Members	Population
Adams	2	0	2	1 week	demand	0		34	57,000
Allegheny	120	120	118	1 month	monthly	0		1,916	1,595,000
Armstrong	0	0	0		as needed	0		60	74,000
Beaver	9	0	9	3 weeks	as needed	0		158	201,000
Bedford	1	1	1	3 months	as needed	0	Hospital Suspension	18	44,200
Berks	5	5	5	2 weeks	as needed	0		310	291,000
Blair	3	3	3	3 weeks	as needed	0		134	137,000
Bradford								72	56,700
Bucks	9	9	6	4 months	as needed	0		224	380,000
Butler	2	2	2	3 weeks	as needed	0		70	122,000
Cambria	1	1	1	1 week	as needed	0		183	187,000
Carbon	0	0	0			0		46	50,700
Centre	5	5	4	3 months	as needed	1	Censure	75	92,000
Chester	12	10	9	3 months	as needed	0		234	264,000
Clarion	0	0	0		as needed	0		13	39,500
Clearfield	0	0	0			0		23	75,500
Clinton	0	0	0		as needed	0		29	38,000
Columbia	0	0	0			0		43	55,000
Crawford	0	0	0		as needed	0		51	80,000
Cumberland	0	0	0			0		55	139,000
Dauphin	17	17	17	3 weeks	as needed	0		405	228,000
Delaware	19		16	6-8 weeks	as needed	0		493	598,000
Elk-Cameron	0	0	0			0		30	44,700
Erie	8	7	8	2 months	as needed	0		237	261,000
Fayette	0	0	0			0		90	158,000
Franklin	0	0	0			0		88	99,000
Greene	0	0	0			0		25	39,000
Huntingdon	0	0	0			0		26	39,500
Indiana	0	0	0			0		37	73,500
Jefferson	1	1	1	1 week	as needed	0		41	43,600
Lackawanna	14	10	9	2-3 weeks	as needed	1	Censure	243	225,000
Lancaster	8	8	7	1 month	as needed	0		285	293,000
Lawrence	3	0	3		as needed	0		77	108,000
Lebanon	0	0	0		as needed	0		78	95,000
Lehigh	8	8	8	1 week	as needed	0		302	240,000
Luzerne	6	6	4	6 months	as needed	0		321	345,000
Lycoming	5	2	3	2 months	as needed	0		124	112,500
McKean	0	0	0			0		30	52,600
Mercer	1	1	0		as needed	0		111	129,000
Mifflin-Juniata	2	2	2	2 weeks	as needed	0		41	62,600
Monroe	0	0	0		as needed	0		57	44,500
Montgomery	15	15	15	1 month	as needed	0		662	616,000
Montour	0	0	0		as needed	0		84	17,200
Northampton	4	4	4	3 weeks	as needed	1	Censure	241	213,000
Northumberland	1	1	1	2 weeks	as needed	0		57	100,000
Perry	0	0	0			0		8	27,000
Philadelphia	143	103	77	1½ - 2 mos	monthly	18	2 Censure, 2 reprimand	3,249	2,015,000
Potter	0	0	0			0		9	16,000
Schuylkill	1	1	1	1 week	as needed	0		125	160,000
Somerset	1	1	1	3 weeks	as needed	1	Voluntary one-year suspension	29	76,000
Susquehanna	0	0	0		as needed	0		15	32,500
Tioga	0	0	0		as needed	0		26	37,200
Union	0	0	0		as needed	0		28	28,500
Venango	0	0	0		as needed	0		61	62,700
Warren	0	0	0			0		57	51,000
Washington	3	3	3		as needed	0		154	210,000
Wayne-Pike	0	0	0		as needed	0		17	39,000
Westmoreland	1	1	1	6 weeks	as needed	0		242	375,000
Wyoming	0	0	0		as needed	0		13	18,000
York	3	1	3	2 weeks	as needed	1	1 censure	223	258,000

IV. Continuing Education Membership Requirement -

The 1970 House determined to require continuing education as a prerequisite of membership in the Society with the AMA Physician's Recognition Award being the instrument through which the program is to be launched. Amendments to the Constitution and By-laws to implement this mandate have been written and appear in the "Official Call."

V. Judicial Council Appeals -

The 1970 House of Delegates directed that the Committee prepare an amendment to the By-laws extending the appeal period to the AMA's Judicial Council from thirty days to sixty days. The necessary resolution was introduced to the AMA and was rejected.

VI. Restructuring of the Medical Defense Fund -

The Board of Trustees and Councilors at its meeting on March 17, 1971 approved the institution of a Group Malpractice Insurance Program for all the members of Pennsylvania Medical Society, such program to commence functioning on June 1, 1971.

The Board of Trustees and Councilors at its meeting on May 12, 1971 reviewed a report submitted to it by the Committee to Study the Medical Defense Fund, which report recommended the development of a Group Malpractice Insurance Program followed by the discontinuance of the Medical Defense Fund. The Board, while agreeing that the Medical Defense Fund would appear now to be not necessary, nevertheless felt that the Board itself should be given the authority to expend moneys of the Society to defray legal expenses associated with the defense of individual members, groups of members or county societies in any case where it believes the best interests of a substantial number of members are so served.

With all of the above in mind, the Board requested the committee to draft the necessary By-law amendments to discontinue the Medical Defense Fund while at the same time granting authority to the Board to expend moneys of the Society to defray legal expenses as indicated above. The committee has prepared such language, and it appears in the "Official Call."

Discipline

The Committee on Discipline has not found it necessary to hold a meeting during 1970-71.

Liaison with the Pennsylvania State Board of Medical Education and Licensure is maintained through membership on the committee by the Chairman of the Board (Charles B. Hollis, M.D., Philadelphia).

The committee's principal activity this year was its survey of component society grievance and disciplinary activities. With 59 of the 60 county societies reporting, or 98.3 percent, the survey showed a total of 433 grievances received in 1970 as compared to 349 in 1969. Of these, 348 required committee action, resulting in 344 cases being closed in 1970, or 79.4 percent of the case load. This compares with 304 cases being closed in 1969, or 80 percent of the case load. Three weeks or less was the time cited most frequently as being required to close a case, with the longest estimates being four to six months. Most grievance committees continue to meet upon the call of the chairman.

Twenty-three disciplinary proceedings were reported, resulting in one suspension, six censures, two reprimands, and one hospital suspension.

Medical Benevolence

Twenty-four family units received assistance amounting to $41,665.00 from the Medical Benevolence Fund during 1970 in monthly grants ranging from $50.00 to $300.00.

During the year the daughter of a deceased member began receiving assistance from the fund. One recipient died; she received a total of $3,300.00 from the fund in twenty-two months.

Several of the persons receiving assistance from the fund have been hard hit by inflation, making it necessary for the committee to increase their monthly allocations. This trend will probably continue in 1972.

In March, 1971, the Board of Trustees changed the philosophy under which the monies of the Medical Benevolence Fund are managed. Authorization was given at that time to invade the principal if necessary. The committee is counting on a slight projected surplus of funds plus the reserve authority to invade the principal to carry it through 1972. It, therefore, recommends that the amount of the annual assessment appropriated to the Medical Benevolence Fund remain at $1.00 per member.

The committee acknowledges the continued strong financial support of the Woman's Auxiliary and its members. Their contributions amounted to $7,823.93 in 1970. Other memorials and contributions brought total gifts for 1970 to $8,059.00.

The financial details of the Medical Benevolence Fund are given in the Accountant's Report for 1970. It is the opinion of the committee that an allocation of $1.00 per active member from the 1972 annual assessment should be sufficient to finance the fund for the year.

Objectives

The Society's By-laws stipulate that it shall be the duty of the Committee on Objectives... "to recommend objectives to the Board of Trustees and Councilors and to the House of Delegates, and to review annually these objectives and recommend any desirable changes." During 1969-70, the committee prepared a series of recommended objectives for the Society which were approved by both the Board and the 1970 House of Delegates.

The 1970 Reference Committee on Reports of Officers, after studying the model plan for Councilor District Reorganization submitted by the Committee on Objectives, stated:

> "Your Reference Committee, while commending the Committee on Objectives for the great effort that produced this plan, feels that reorganization along the lines suggested by the Committee on Objectives is not the best way to satisfy the aims as stated by the Committee on Objectives on page 76 of the Official Reports Booklet.
>
> "Your Reference Committee, therefore, recommends that this matter be referred back to the Committee on Objectives to propose alternate methods of

obtaining the five goals referred to in the Committee's report."

The five goals referred to above are:

"1. Secure greater grass roots participation in the work of organized medicine.

2. Improve communications.

3. Coordinate private and public health related programs.

4. Foster cooperation, and coordination among contiguous county societies at the working committee level.

5. Promote more efficient county societies."

Because support was lacking for reorganization of the Society as suggested in the committee's Model Plan, the committee has determined to pursue its five objectives through existing Society framework. It is hoped that some of the recommendations which appear in this Annual Report, if implemented, will help achieve the five goals of the Model Plan.

Three meetings of the committee were devoted to the subject "How Can Organized Medicine in Pennsylvania Be Improved?" To assist the committee in this study, a number of consultants were invited to participate in the committee's meetings. They included Mr. Mark Berger, SAMA, Hahnemann Medical College, Philadelphia; Rocco Chirieleison, M.D., chief medical resident, Reading Hospital; Mr. Norman V. Lourie, deputy secretary, Department of Public Welfare; Harry M. Woske, M.D., associate dean, University of Pennsylvania School of Medicine; Edward J. Kowalewski, M.D., past-president, American Academy of Family Physicians; Mr. Louis B. Rubinsohn, district manager, Wyeth Laboratories; Mr. David W. Powers, director of management services, American Medical Association; Angelo P. Angelides, M.D., director of medical education, Lankenau Hospital; and Dean F. Dimick, M.D., chief of medicine, Allentown Hospital.

Testimony from these consultants along with the results of a preliminary survey of medical school graduates, class of 1960, have resulted in the following recommendations:

1. The committee recommends that the Pennsylvania Medical Society continue to support the long range objectives adopted by the 1970 House of Delegates.

The committee supports the council's efforts in effectively utilizing community teaching hospitals in its continuing education programs, and encourages further involvement in this area.

The committee heartily supports the principle of a continuing education requirement for membership in the State Society and urges continued efforts to simplify the current certification procedure.

The committee notes with approval the White Paper on Emergency Medical Services, published in the June issue of PENNSYLVANIA MEDICINE and encourages the membership to read this document and implement its findings at the local level.

The committee recognizes the council's efforts to improve school health programs throughout the Commonwealth and urges the council to continue its work with the Department of Education in this regard.

The committee applauds the council's efforts to achieve a more precise definition of the functions and education needs of physician assistants.

2. The committee recommends that the Council on Education and Science work with the deans of Pennsylvania's medical schools to revise their curricula and postgraduate opportunities to produce additional general practitioners for the Commonwealth.

The committee approves the concept of the Pennsylvania Medical Care Foundation as being in harmony with the development of programs of health care services and facilities in such a way as not to be detrimental to existing, proven methods of health care delivery. In this regard the committee believes that recipients of health care should be required to pay at least partial costs of each health care service in order to maintain efficient utilization, and urges that Society programs reflect this concept.

Testimony at public hearings held in Philadelphia indicates that money originally allotted for health care services and facilities has been used to subsidize medical education.

3. The committee recommends that the Pennsylvania Medical Society support the concept that only educational funds should be used to finance postgraduate medical education.

The committee applauds the council's efforts in sponsoring courses on the economics of medical practice in teaching hospitals and medical schools. The committee urges the Society to promote the inclusion of these courses in the undergraduate curriculum of Pennsylvania Medical Schools.

4. The committee recommends that the Society give priority to the involvement of young physicians in organized medicine by using the "Detail Man" concept.

The committee views the cooperation of directors of medical education as vital.

5. The committee recommends that the Council on Public Service direct news releases to directors of medical education to improve communications and assist in recruitment of young physicians.

Copies of the transcripts of the consultants' remarks were distributed to the editors of the county society bulletins and PENNSYLVANIA MEDICINE as resource material.

Study Relations Between Medicine and Osteopathy

The Committee to Study Relations Between Medicine and Osteopathy reports that it has held no meetings so far this year, but that individual members of the committee have had conversations with state and national osteopathic leaders. The committee also reports that five county medi-

l societies have accepted osteopaths to membership and at these doctors, in turn, have become members of the ate Medical Society.

The committee also calls attention to the liaison being conducted between various councils and committees of the Pennsylvania Medical Society and the Pennsylvania Osteopathic Medical Association in the area of public relations, legislation, and malpractice insurance coverage.

Reports of Special Committees

General Practice

Your Special Committee on General Practice did not eet during the year. This came about for diverse reasons: ie ecologic movement (our contribution being a reduction waste paper); the conservation movement (our concern eing manifest by sparing the committee members' time and ie Society's money); and finally, the nullity of matters eferred to the committee by the House and the Board.

Since the establishment of this committee, family practice residencies have increased in number, medical schools eem to be inclined to train family practitioners, and the merican Board of Family Practice has come into existence. These are encouraging signs of progress on a national evel and suggest that reports of the demise of general practice may have been premature. We, of course, take no credit whatever for any of the above accomplishments.

We recommend that the committee be discharged. We urther recommend that the preceptorship program be continued under the Council on Education and Science and hat the group practice information service be continued nder the Council on Public Service.

Lay Advisory on Health Care

This committee, organized by the Board of Trustees in anuary, 1970, after approval of the concept three months earlier by the House of Delegates, has several inherent problems in moving quickly to accomplish its broadly defined purpose "of acquainting non-medical leaders with he problems facing the medical profession and soliciting he advice of these leaders to aid in their solution."

In choosing leaders from business, education, industry, labor, law, religion and government, the criteria resulted in the selection of people who already had massive demands on their time. This has made the scheduling of meetings, at which a majority of the members might be able to be present, an extremely difficult task. Despite half a dozen different attempts to schedule meetings, only two meetings have been held— the first in July 1970, and the second in June 1971. This continuing difficulty has resulted in a committee recommendation, approved and implemented by the Board, that the non-medical members be expanded from the original seven to eleven.

The original non-medical members were: Mr. George L. Cullen, vice-president, Strawbridge & Clothier, Philadelphia; Dr. Charles H. Watts, II, Ph.D., president, Bucknell University, Lewisburg; Reverend Paul M. Washington, rector of the Church of the Advocate, Philadelphia; Mr. Patrick M. Greene, director of Community Service Activities, Pennsylvania AFL-CIO, Harrisburg; the Honorable J. Quint Salmon, judge, Beaver County Court of Common Pleas, Beaver; Mrs. John M. Spatz, Federation of Women's Clubs, Pittsburgh; and U.S. Rep. John H. Ware, Oxford. Those that have been asked to serve on an expanded committee are: Mr. Everett P. Zurn, chairman of the board, Zurn Industries, Inc., Erie; Dr. Leonard N. Wolf, Ph.D., vice president, University of Scranton, Scranton; Mr. John T. Ryan, Chairman of the Board, Mine Safety Appliances Company, Pittsburgh; and Miss Rebecca F. Gross, vice-president, "The Express", Lock Haven. The physician ex-officio members of the committee include Chairman of the Board of Trustees Park M. Horton, M.D.; President William A. Limberger, M.D.; President-Elect George P. Rosemond, M.D.; and Immediate Past-President William A. Barrett, M.D.

At the initial meeting of the committee, the committee members elected Mr. Cullen as chairman and Dr. Watts as vice chairman. That initial meeting was devoted almost exclusively to a discussion of current State Society activities and concerns. At the second meeting of the committee, an exploration of specific problems was started. These included health and medical care cost control efforts; the production of more physicians, the types of physicians needed and the distribution of medical manpower. On the agenda for possible future review are the chiropractic problem and the State Society's public and professional relations activities.

The committee is scheduling a third meeting for September because it has expressed a sense of urgency in arriving at specific recommendations in the health and medical care cost and manpower areas that will be of possible benefit for both the public and the profession.

Medicine and Religion

The committee has not functioned as actively during the past year as it has in prior years, mainly due to the resignation of the previous chairman and the interim period until a new chairman was appointed. Hopefully, the committee can move forward with vigor in the coming year.

The chairman attended the Regional Medicine and Religion Workshop of the AMA in New York City during February, 1971. The excellent program once again provided several ideas which may be of use in Pennsylvania. Some of the suggestions under consideration are the use of volunteer seminarians in the hospital emergency room; closer relationships with the clinical pastoral education group; the institution of postgraduate education in medicine and religion for interns and residents; and the rejuvenation of county society committees.

The committee believes there has not been enough attention directed to maintaining local interest in medicine-religion activities and, as such, plans to direct more effort to those county societies where interest has waned.

We will continue to work for the development of medicine-religion programs in the seminaries, in cooperation with the appropriate county societies and clinical pastoral education groups.

Relationships with Allied Professions

The Committee on Relationships with Allied Professions reports that it has held another Physician/Nurse Seminar during the year at the Society's headquarters building, and this year has involved representatives of the Hospital Association of Pennsylvania, which they thought was extremely helpful. The committee also reports that Pennsylvania is one of nine states selected by the National Commission for the Study of Nursing and Nursing Education for a pilot program in the establishment of joint state practice commissions and a statewide master planning committee for nursing education. The purpose of the two permanently established committees is (1) to determine the utilization of nurses in providing health care; (2) to study the development of career perspective in nursing practice; (3) to consider the expansion of the role of a nurse to insure that their talents and capacities are fully used; and finally, (4) to discuss all other related problems between hospitals, nurses and physicians.

The committee also reports that it continues to be interested in liaison with the Pennsylvania Podiatry Association and has sponsored an article which appeared in the April, 1971 issue of PENNSYLVANIA MEDICINE, as an educational device for physicians as to the proper utilization of doctors of podiatry.

Reports of Administrative Councils

Education and Science

Following is a summary of the activities of the Council.

Hospital-Based Educators— At the AMA Congress on Medical Education in February, the council held a continental breakfast meeting for forty-two Pennsylvania hospital-based educators. At this session, the concept of PMS educational program organization was presented. There was an interchange between the various hospital-based educators on ways to be effective in educational activities.

Joint Statements on Inhalation Therapy and Sterile Vaginal Examinations— At the request of the Pennsylvania Nurses Association, the council reviewed and finally approved two statements that would endorse principles for various aspects of professional nursing practice. A statement on inhalation therapy contended that the registered nurse may assume the responsibility for administering inhalation therapy, as ordered by the physician, provided certain conditions were met. A second statement recognized that sterile vaginal examinations may be done by a registered nurse to determine the progress of a patient during labor.

Community Hospital Courses— Fifteen community hospital courses were sponsored by the council and the Educational and Scientific Trust. Preliminary reports indicate that the total registration and average attendance have risen for all areas which were included in the 1969-70 report. The council chairman has found that he will not be able to plan and develop future courses as he has done in the past. William M. Cooper, M.D., director of continuing education at the University of Pittsburgh School of Medicine, has agreed to plan the programs for Bradford, DuBois, Sharon, St. Mary's, Kittanning, and Uniontown. Joseph P. Scottino, Ph.D., program director for the physicians continuing education program at Gannon College, Erie, will develop the program for the Meadville area in cooperation with the local course director. Several directors of medical education in the Susquehanna Valley Regional Medical Program area have offered to assist with the planning of the courses there. This includes Gettysburg, Hanover, Lewistown, Lock Haven, and Wellsboro. Their expenses will be reimbursed from funds made available by SVRMP. There are only two of our courses in the eastern part of the state, and we have been fortunate enough to secure the assistance of the Medical College of Pennsylvania and the Delaware Valley Regional Medical Program in the planning of these. Since we started these courses in small community hospitals in 1969, we know there has been some success in developing an "appetite" for continuing education among the membership in these areas.

Hospital Library Conference— Using the theme, "A Partner of Medical Education," two conferences on the hospital library were held in April. The goal of the conference was to provide in a community hospital a library service that will be a meaningful part of the continuing education program for physicians and allied professions.

MECO Program— The Medical Education-Community Orientation Program of the Student American Medical Association was approved by the Board of Trustees. On special letterhead, which was signed by Dr. Limberger and Edwin L. Taylor, the president of the Hospital Association, was an invitation to hospitals to participate in the program. This letter was mailed to 143 hospitals in Pennsylvania, selecting those that did not have resident and intern training programs. Fifty-two replies were received and reported to the MECO state project director at the University of Pittsburgh School of Medicine and to the Hospital Association of Pennsylvania. Of these, twenty-eight were indications for participation, which requested a total of sixty-eight students.

Medical Education Administration— On March 19, a conference for hospital-based educators was held regarding medical education administration. Through a workshop format, the attendees developed educational objectives, planned methods of evaluation of programs, developed skills in identifying educational needs, prepared individual physician educational profiles, and role-played situations where the director of medical education became a coordinator of medical education in a community hospital.

Medical Education Resource Center— Reported in the 1970 Annual Report was the development of a videotape dubbing service on medical subjects for Pennsylvania medical schools, hospitals, and other educational institutions. The three regional medical programs and the Pennsylvania Medical Society have provided 106 hours of videotape, at a cost of $5,000, to be used for master programs. The dub-

ing service, which will be instituted in the summer of 971, will utilize facilities at the State Department of Edu- ation to transcribe programs selected from a catalog onto a lank videotape compatible with the equipment of an insti- ution requesting the dubbing service. The only cost to the nstitution will be return postage. The advantage to the in- ditution is that they can maintain their own tape library or ney can erase and use the tape at a later date for new pro- rams at a reasonable cost.

Peer Review (Medical Audit) Activity— "Guidelines for 'eer Review (Medical Audit) Activity at a County Medical Society Level" have been distributed to all county medical ociety secretaries, presidents, and executive secretaries, as vell as to the president of the medical staff of each hospital, nd to all directors of medical education and others who are nterested in the organization of medical education pro- grams. The council also, in a related action, approved the levelopment of audit teams that would be made available to community hospitals. Such teams would teach hospital staff nembers how to determine the educational deficiencies of he staff and then how these deficits can be corrected hrough educational programs.

Pennsylvania Medical Continuing Education Institute— The Society has proceeded to incorporate the Pennsylvania Medical Continuing Education Institute. Incorporation was sponsored by the Pennsylvania Medical Society, Pennsyl- vania Osteopathic Association, and the Keystone Medical Society. The institute will be a statewide organization created to permit various sponsors and purveyors of con- tinuing medical education to pool their resources without losing their basic autonomy.

PMS Membership Requirement— AMA Physician's Recognition Award— The Advisory Committee on Con- tinuing Medical Education has reviewed the requirements of the AMA Physician's Recognition Award, as directed by the House, and has recommended the following changes:

1. Credit should be given for audio digest instruction, reading of scientific articles and professional journals, and any other such programs that are offered as a part of a hospital's continuing education program.
2. Credit should be given for self-assessment examina- tions.
3. The description of courses under category 4 should be expanded to include all types of continuing education courses that physicians in various types of practice could use to improve their services; for example, man- agement courses for administrative specialists, teaching technique seminars for educators. After these recommendations were made, the AMA's Board of Trustees appointed a special ad hoc committee to review all the requirements and make recommen- dations for change.

Production of Physicians— In the 1970 Annual Report, the council called attention to its statement regarding the production of more physicians from Pennsylvania medical schools. The deans of Pennsylvania medical schools raised a number of objections about the statement. The council has been meeting with representatives of the deans and the Department of Education Bureau of Planning in order to prepare criteria and a formula that would be agreeable to all parties for use in securing funds for medical education beginning in 1973 and to develop a new statement on the production of physicians.

Scientific Assembly— All of the innovations that were planned for the 1970 Scientific Assembly were well received and will be continued during the 1971 assembly. The theme again will be "Clinical Therapeutics— 1971: Emergency Medicine." This year four Pennsylvania medi- cal schools— Hershey, Penn, Temple, and Woman's— have each planned a seminar for one morning. The Pennsylvania Nurses Association has been represented in planning discus- sions and has appointed a planner at each of these medical schools to develop an afternoon program for nurses, which will be coordinated with that being presented in the morn- ing for physicians. Twelve specialty societies and two of the State Society's commissions are also planning programs for the assembly.

Self-Assessment Examinations— Data regarding twelve self-assessment examinations has been compiled for publica- tion in PENNSYLVANIA MEDICINE. The summary gives basic information regarding the type of examination, who is eligi- ble, charges, and the name and address of the person to con- tact for further information. This will give all members of the Pennsylvania Medical Society a ready reference to the many self-testing educational opportunities that are avail- able today.

Medical Corpsmen— The development of Project MEDIHC by the federal government fills a need for place- ment and counseling for ex-medical corpsmen, including both those ex-corpsmen desiring further education and those merely needing placement. The Advisory Committee on Manpower and Allied Professions works closely with MEDIHC (Pennsylvania's official agency is the Hospital Educational and Research Foundation) and is publishing in PENNSYLVANIA MEDICINE several articles alerting physicians to the basics of the program and where to get more information.

Physician's Assistant Programs— Questions by physi- cians regarding the legal aspects of hiring physicians' assis- tants led to an article in PENNSYLVANIA MEDICINE stating the opinion of legal counsel on the issue; namely, that a physician may utilize allied medical personnel in any desired capacity, but is liable for the acts of these personnel in the event of a malpractice suit.

Revision of Medical Practice Act— Members of the council and staff directly participated in rewriting a draft for a new medical practice act. To be incorporated into the proposed new act will be language to clarify the physician's liability and responsibilities in utilizing allied medical per- sonnel and to provide for broader interpretation and greater flexibility in the development of curriculum in Pennsyl- vania medical schools.

Support for AMA-AHA Moratorium on Licensure of Allied Medical Personnel— The AMA-AHA have called a moratorium on licensure of emerging allied health per- sonnel groups. The council and the Board of Trustees sup- port the moratorium. The moratorium is conceived as one step toward allowing flexibility and encouraging experi- mentation in physician's assistant training and use.

Vocational Training for Health Assistant— The Bureau of Vocational, Technical, and Continuing Education of the Department of Education is developing a health assistant

program at the high school level. This is to be a two-year course in the eleventh and twelfth grades and will be offered at technical high schools. This program will expose more students to the potential of careers in health and cut down the lead time necessary for the production of a health assistant.

Emergency Medical and Health Services in Pennsylvania— A white paper on emergency medical services has been completed and approved by the Board of Trustees. Part I— The Present Status— explores current data as to the state of emergency medical services in Pennsylvania. Part II— Recommendations— presents thirty-four specific recommendations for improvement. The white paper was published in the June issue of PENNSYLVANIA MEDICINE and distributed in reprint form to legislators, local government officials, ambulance associations, and other interested parties.

Toronto Conference on the Great Lakes— Last year, a two-day conference hosted by the Ontario Medical Association was held in Toronto. The conference adopted seven major recommendations, the most important of which was that an international body with full regulatory powers throughout the entire Great Lakes drainage basin be formed. The Pennsylvania Medical Society's position on the pollution of the Great Lakes was presented to the secretary of the Department of Environmental Resources.

Second Career Workshop— The commission sponsored a "second career" workshop. The workshop began the development of an educational course to meet the needs of the already practicing physician desiring to begin a second career as an emergency room physician. Six of the seven Pennsylvania medical schools were represented at the workshop, as was the American College of Emergency Physicians.

Awards— The 1969 Occupational Health Award for small companies (under 500 employees) was presented to the Alcoa Aluminum Co. at New Kensington. This was the last presentation of the Occupational Health Award. The award was discontinued because of the lack of interest by industry. The commission is in the process of developing criteria for an environmental health recognition award to go to individuals, voluntary groups, or corporations which have made outstanding contributions to improving the environment.

Information and Referral Service for the Aged— The commission has submitted to the Office of Aging of the Department of Public Welfare an article outlining the recently established information and referral service in Maryland. The commission expects that favorable action will ensue, leading to the development of a similar program in Pennsylvania in the very near future.

Position Paper on Home Care— At the request of the Board of Trustees, a position paper on home care, which defines the home health aide and the homemaker services was prepared.

Commitment of Protesting Patients— The commission continues to be concerned with commitment problems under the MH/MR Act of 1966. A task force, composed of legal and psychiatric representatives, was appointed by the Deputy Secretary of Mental Health/Mental Retardation to study and resolve these problems. The commission presented a position statement to the task force studying the commitment problems, again calling for the use of the original interpretation of Section 404 with supportive reasoning. The task force is still continuing its investigation and is expected to issue a report shortly.

Regional Drug Abuse Education Programs— The commission, the Pennsylvania Academy of General Practice, and the Departments of Health and Public Welfare are currently involved in planning a series of educational programs for physicians to assist them in recognizing and treating drug addicts. The program will be a one-day session in eight different cities in order to reach a maximum number of physicians. The content has been broken down into four major topics: (1) the magnitude of the drug abuse problem in Pennsylvania; (2) medical-legal aspects of drugs; (3) medical-pharmacological considerations of the drugs of abuse; and (4) major methods of treatment of drug addiction.

Governmental Relations

The Council on Governmental Relations reports that it has had several meetings during the year and will hold others since the amount of legislation before both the Legislature of the Commonwealth and the Congress of the United States is extremely heavy. The council suggests that it is too early to include in its report a list of legislation and the actions taken on the various bills, and that a supplementary report confined to legislative activities will be written and distributed closer to the meeting of the House of Delegates— consequently, the report of the council is confined to activity referred to it by the House of Delegates and the Board of Trustees.

The council comments on an action taken by the House to the effect that the Society should adopt a receptive attitude towards the support of countersuit brought by one of its members as a result of malpractice action. The council reports that it could not support this concept and reprints comments from general counsel sustaining its feelings. One of the key paragraphs from general counsel's letter seems to be particularly germane— "Finally, I believe the chances of success in any large number of cases would be so slim as to have very little, if any deterrent effect. Presuming a dishonest or greedy attorney in the first instance, such traits would result in a false defense in the 'Abuse of Process' claim and make proof by the doctor of knowing perjury, etc., by discovery requiring scrutiny of the files of plaintiff's attorney, a virtual impossibility..... We advise against countersuits except where a knowingly false claim or malicious motive can be proved by independent fact witnesses. Such cases should be reviewed by an experienced trial attorney on a case-by-case basis and the expenses and risks should then be weighed against the chances of success and any deterrent effect that success may have."

The council also reports on its follow-up activity with regard to chiropractic legislation, informing county medical societies of individual legislator's voting records, activities with respect to supporting the budgetary requests of medical schools, termination of chiropractic licensing in Pennsylvania, abortion legislation, prepaid hospital and medical insurance contracts for Department of Public Welfare clients, efforts to consolidate health-related activities in the

Department of Health and, finally, activities of its Commission on Forensic Medicine's meeting with the Pennsylvania Bar Association on "Fee for Service Concept" for attorneys.

The council also reports on several pieces of legislation referred earlier in the year by the Board of Trustees, and, finally, a successful visit with Pennsylvania's congressmen by representatives of the council and county medical society representatives in Washington this past summer.

Medical Service

The following is a summary of the most significant activities and actions of the Council on Medical Service during the past year.

The council:

Continued to assist and advise Pennsylvania Blue Shield in the development and expansion of the Prevailing Fee Program and offered guidance and support in the development of up-dated doctor profiles.

Provided continuing consultation to Pennsylvania Blue Shield with respect to their role as carrier for Medicare Part B, CHAMPUS, and as fiscal administrator for Pennsycare by outlining a number of problem areas and recommending administrative changes for improvement.

Approved osteopathic representation on the Western Pennsylvania PMS - Blue Cross Regional Steering Committee to assure continued cooperation of osteopathic physicians' hospitals in the PMS - Blue Cross Medical Advisory Committee (MAC) Program.

Continued to monitor and present testimony, where appropriate, at public hearings conducted by the State Insurance Department relative to Blue Cross rate increase requests.

Expanded to twenty-one the number of specialty advisory committees utilized by the council in its peer review activities.

Continued to meet with representatives of various governmental agencies and medicare carriers in an effort to improve liaison and to develop a better understanding of the Society's review activities.

Continued to meet with representatives of the Department of Welfare in an effort to seek improvement in our medicaid program. The council was instrumental in the development of the state's Hospital Rules and Regulations.

Approved the offering of a PMS Professional Liability Insurance Program in keeping with the provisions of the "Model Malpractice Insurance Program" developed by the council in 1969. The program affords a high degree of physician involvement and represents the most progressive and comprehensive coverage available.

Continued to maintain surveillance over Society endorsed insurance programs, and in addition to approving an up-grading of the Major Hospital and Surgical Expense Coverage, the council approved the offering of a comprehensive Blue Cross-Blue Shield program in the Capital Blue Cross service area.

Continued to assist members and interested agencies throughout the state in the development of CHP and provided liaison with the State Office for Comprehensive Health Planning.

Initiated efforts to develop a Pennsylvania Medical Care Foundation. The council's Subcommittee on Medical Care Foundation has been actively engaged in the development of organizational and operational guidelines.

Initiated the development of hospitalization criteria by the specialty advisory committees to be used in the Pennsylvania Medical Care Foundation.

Sponsored a meeting with providers, consumers, government and industry representatives describing the foundation concept and its application to present health care needs.

Public Service

Political forces are leading a growing public dissatisfaction with the cost of health and medical care and with the entire health care delivery system itself.

The size and number of the forces leading this movement are such that the dollars that organized medicine can bring to bear in opposition are but a drop in the bucket compared to what is needed. In addition, at a time when our best available weapon is responsible individual and group physician action, evidence of individual action is decreasing and a growing lack of involvement in and commitment to the organizations of medicine makes group action much more difficult.

Today's physicians individually and collectively are not demonstrating the same degree of patient rapport and concern that allowed them to ascend in public esteem and confidence. As patient pressures increase the demands on their time, physicians give more of the science and less of the art of medicine to their patients. To a far greater degree, it is the art of medicine that produces patient rapport. Although concern for the individual undoubtedly exists in the medical profession to a degree greater than in any other profession, it still is slipping and the descent is adding to attitudes that are not in the best interest of either the public or the profession. The change in physician practices and attitudes undoubtedly is due in part to an affluence that in itself adds to public resentment.

Today's medical school graduate not only is a product of his times but he also in general is the product of a curriculum and a medical school environment which stresses the science of medicine, largely ignores the art of medicine, and degrades the role of the primary physician. The more impersonal the practice of medicine becomes, the greater the profession's public relations problems.

Companion to these changes impacting on public attitudes are those that have decreased the physician's commitment to the organizations of medicine. Affluence is a poor binding agent. Adversity is a much stronger glue but the adversity that faces the medical profession today all too often is regarded as a distant ache that doesn't require immediate action rather than as an immediate, acute pain that demands steps now.

The voice of the Pennsylvania Medical Society is heard only to the degree that the members are willing to listen. There seems to be a growing unwillingness to listen which again may be a product of affluence and a lack of recognized immediacy to the problems discussed. This decreased membership involvement in and commitment to both the public and professional interest goals of the Medical Society makes their accomplishment extremely difficult and

perhaps even impossible.

It is in this atmosphere that the Council on Public Service attempts to carry out its public and professional relations responsibilities. It wishes that it had a way to instill in each physician the attitudes and actions that would enhance the profession's public relations to a far greater degree than any organizational activity can. It hopes that it can find a way to increase membership involvement even if the binding force is economic rather than altruistic. To this end, it is exploring projects of direct service to members that would make medical society membership economically advantageous. One such idea being explored is that of a physicians' cooperative. Along with the dismay over what needs to be done and the barriers to its accomplishment, the council is proud of what it has been able to do despite the budget restrictions that inflation has brought.

A new council responsibility is shepherding on an interim basis the public and professional education components of the State's Uniform Anatomical Gift Act. Although the act has been law since January 1, 1970, almost nothing had been done to alleviate an inhibiting shortage of bodies for teaching and research purposes and a growing shortage of body parts for transplantation. The lack of activity was due to reluctance of any single agency to coordinate and carry out essential activities. Acting on a council recommendation, the Board of Trustees has agreed that it will seek legislation to have a state agency appropriately constituted and funded to carry out all gift act activities. Because such a step may be some time in the future, the State Society also agreed that the council should meet this role on an interim basis and the council has developed public and professional educational materials, donor cards, articles for journals and the mass media, and information for the broadcast media. Professional education components are being funded in part by the Educational and Scientific Trust of the Pennsylvania Medical Society.

Among its many television activities, the council produced at an astonishingly low dollar cost a documentary program examining delivery problems in the state, the profession's activities and concerns with these problems. It called on greater continuing support for medical education to increase physician production if the delivery problems are to be solved. All or major portions of the program were telecast in every major market of the state. Virtually all residents of the state were within one or more of the primary telecasting areas of the eight stations involved.

In addition, the council has continued its weekly radio show used on eighty stations and a variety of other radio and television activities as well as projects for newspapers and other printed media. It has continued efforts to improve and implement four awards programs— the Benjamin Rush Awards for lay contributions to health, the Donaldson Awards for media reporting of health topics, the Centenarian Awards for those who achieve the age of 100, and the Fifty-Year Awards for physicians who have been in the practice of medicine for that period.

The council has kept county society bulletin editors abreast of State Society and related news through periodic mailings. It has prepared and disseminated the Service Manual which provides to county society officers detailed information about most of the major programs and activities of the State Society. It has written and produced a variety of printed materials on both public and professional topics.

It has supervised the State Society Speakers' Bureau, the forty-five members of which have done yeoman service on behalf of medicine before both lay and professional groups. Its health careers recruitment activities, with a major public relations component, have advanced significantly throughout the state. Activities for students, interns, and residents have included the presentation of a socio-economic course in general hospitals and meetings with representatives of SAMA chapters. Guidance and financial support has been provided to medicine's superb friends, the medical assistants whose organization has been renamed the "Pennsylvania Society, American Association of Medical Assistants."

Thousands of pieces of health education literature have been distributed in response to an almost continuous flow of requests from individuals and groups. With special concern for rural health delivery, the council has been actively exploring mobile clinic demonstration projects and a mobile laboratory concept to assist physicians in isolated areas where laboratory services are comparatively inaccessible. It has been using exhibits at a number of events to increase health education and a film library largely devoted to drug abuse has been in almost constant use.

The council has continued to invite new county society secretaries to a day-long orientation visit at the state society headquarters and it has arranged for a number of county medical societies to hold meetings in the PMS building to increase membership awareness of state society activities. It has continued efforts to increase non-member awareness of State Society goals and activities and this has met with considerable success.

Each of the items listed is covered in detail in the council's full annual report which we hope will be read by every member of the State Society. The council would welcome any inquiry about its activities.

Pennsylvania Delegation to the AMA

As mandated by the 1970 PMS House of Delegates and the Board of Trustees, the Pennsylvania Delegation to the American Medical Association introduced three resolutions during the Clinical Convention of the AMA held in Boston, Massachusetts, November 29-December 2, 1970, as follows

1. Homemaker Services
2. White House Conference on Aging
3. Allocation of federal funds for Health-Related Grant and Aid Programs.

The delegation plans to nominate Russell B. Roth, M.D. for Speaker of the AMA House in 1971 and to nominate him for AMA President-Elect in 1972.

A supplemental report will be submitted, since the Annual Meeting of the AMA will be held June 20-24, 1971.

INTERMITTENT COURSES

Listed below are courses of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, contact the director at the address given in the course listing.

CODE KEY

S—Designed for full-time specialists
AAGP—American Academy of General Practice
ACGP—American College of General Practitioners in Osteopathic Medicine and Surgery
AMA—AMA Accredited Educational Institution (Eligible for AMA Physician's Recognition Award Credit)
PMS—Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
M.S. Hershey—Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Pitt—University of Pittsburgh School of Medicine
Penn State—Pennsylvania State University
Temple—Temple University School of Medicine
U. of Pa.—University of Pennsylvania School of Medicine
MCP—The Medical College of Pennsylvania

CARDIOVASCULAR DISEASES

ayre; June 28, 1971—February 1, 1972
Rotating Specialty Seminar/Cardiovascular Disase; at Robert Packer Hosp.; 1 hr. per day; 1 day er week; 17 weeks; 17 hrs. AAGP credit pproved. Contact Paul C. Royce, M.D., Ph.D., .M.E., Robert Packer Hosp., Guthrie Square, ayre 18840.

DERMATOLOGY

ayre; August 10, 1971—June 6, 1972
Rotating Specialty Seminar/Dermatology; at obert Packer Hosp.; 1 hr. per day; 1 day per eek; 6 weeks; 6 hrs. AAGP credit approved. Conact Paul C. Royce, M.D., Ph.D., D.M.E., Robert acker Hosp., Guthrie Square, Sayre 18840.

ENDOCRINOLOGY

ayre; July 20, 1971—May 23, 1972
Rotating Specialty Seminar/Endocrinology; at obert Packer Hosp.; 1 hr. per day; 1 day per eek; 9 weeks; 9 hrs. AAGP credit approved. Conact Paul C. Royce, M.D., Ph.D., D.M.E., Robert acker Hosp., Guthrie Square, Sayre 18840.

FAMILY MEDICINE

ershey; September 28, 1971—June 27, 1972
Newer Aspects of Family Medicine; at Hershey; hr. per day; 1 day per week; 40 weeks; 40 hrs. AGP credit approved. Contact Thomas L. eaman, M.D., Chrm., Dept. of Family & Communi- Medicine, M.S. Hershey, Hershey 17033.

GASTROENTEROLOGY

hiladelphia; March 3 - April 7, 1972
AMA — Gastroenterology Seminar (Basic Conepts in the Modern Diagnosis & Management); at ahnemann; 3½ hrs. per day; 1 day per week; 6 eeks; 21 hrs. AAGP credit requested; fee = $60. ontact Frederick K. Heath, M.D., Dir., Cont. duc., Hahnemann, 230 N. Broad St., Philadelphia 9102.

GENERAL MEDICINE

bington Memorial Hospital; September 15—. ecember 1, 1971
Psychiatry for the Family Practitioner; by Montomery County Academy of Family Practice; 2½ rs. per day; 1 day per week; 10 weeks; 25 hrs. AGP credit requested; max. enrollment=30; ee=$25. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Abington Memorial Hospital; January 20—March 21, 1972
Endocrine Problems in Family Practice; by Montgomery County Academy of Family Practice; 2½ hrs. ea. day; 1 day ea. week; 10 weeks; 25 hrs. AAGP credit requested; max. enrollment=30; fee=$25. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Allentown Hospital; September 9, 1971 - June 8, 1972
AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; 1 day ea. mo.; 3 hrs. ea. day; 30 hrs. AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Altoona Hospital; October 7, 1971 - May 18, 1972
AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; 2 days ea. mo.; 2 hrs. per day; AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 16, 1971 - May 18, 1972
AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; at St. Luke's Hosp.; 1 day ea. mo.; 3 hrs. per day; AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford; October 19, 1971 - May 16, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; at Penn Hills Club; third Tues. ea. mo. except Dec. and Jan.; 18 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Chester; September 7, 1971—May 23, 1972
AMA— Continuing Education Program; at Crozer-Chester Med. Center; by Hahnemann; 2 hrs. per day; 1 day per week; 38 weeks; 76 hrs. AAGP credit requested; 76 hrs. ACGP credit approved. Contact Frederick K. Heath, M.D., D.M.E., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Coatesville VA Hospital; September 23, 1971—May 25, 1972
The Laboratory and the Clinician; 1 hr. a day; 1 day per mo.; 9 hrs. AAGP credit requested. Contact John C. Cottrell, M.D., Chief, Laboratory Services, Coatesville VA Hosp., Coatesville 19320.

DuBois Hospital; February 10 - April 13, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; Thurs. ea. week; 30 hrs. AAGP credit requested, fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

East Stroudsburg; October, 1971 - April, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and M.C. of Pa.; at General Hosp. of Monroe County; 3 hrs. per day; 1 day per mo.; 6 mos.; 18 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Easton Hospital, September 15, 1971—June 21, 1972
AMA— What's New in Basic Concepts of Each Sub-Division of Medicine; by Hahnemann; 2 hrs. per day; third Wed. ea. mo.; 16 hrs. AAGP credit requested. Contact Horace Y. Seidel, M.D. Dir., Dept. of Medicine, Easton Hosp., 21st & Lehigh Sts., Easton 18042.

Gettysburg; January 11 - April 19, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; at Annie Warner Hospital; every-other week, alternating Tues. and Wed.; 24 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Hanover General Hospital; October 20, 1971 - May 18, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; one ea. mo. except Jan. and Feb.; 12 hrs. AAGP credit requested. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Harrisburg; September 30, 1971—January 20, 1972
Continuing Education Program 1971-1972; at Community General Osteopathic Hosp.; 8 Thurs.; 2½ hrs. per day; fee=$60 ($10 ea. single session); AAGP and ACGP credit requested. Contact Charles M. Worrell, D.O., D.M.E., Community Gen. Osteopathic Hosp., 4300 Londonderry Rd., Harrisburg 17109.

Hazleton State General Hospital; September 1 - June 1
AMA (required credit) — A Program of Continuing Medical Education; by U. of Pa.; 1½ hrs. ea. day; Thurs. ea. week; 36 weeks; 54 hrs. total; 40 hrs. AAGP credit approved. Contact Robert Gunderson, M.D., D.M.E., Hazleton State Gen. Hosp., Hazleton 18201.

Kittanning; December 2 - 16, 1971
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; at Armstrong County Memorial Hosp.; every Thurs.; 6 hrs. AAGP credit requested, fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Lancaster General Hosp.; September 7, 1971 - May 30, 1972
Continuing Education Program; 1 day per week; 3 hrs. per day; 29 days; AAGP credit requested; fee = none. Contact John H. Esbenshade, Jr., M.D., Dir. Med. Educ., Lancaster General Hosp., 555 N. Duke St., Lancaster 17604.

Lancaster Osteopathic Hospital; September 23, 1971 - May 25, 1972
AMA — Continuing Education Program; by Hahnemann; 2 hrs. per day; 1 day per week; 17 weeks; 34 hrs. AAGP and ACGP credit requested. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Lebanon; October 7—November 11, 1971
Drug Abuse; by Consult, Inc. (Lebanon Co. Commission of Drug Abuse) and the Institute of Pa. Hosp.; at Lebanon Municipal Bldg.; Thurs. ea. week; six weeks. Contact Raymond R. Curanzy, M.D., 39 E. Maple St., Palmyra 17078.

Lebanon; November 3, 1971 - May 2, 1972
AMA — A Continuing Medical Education Program; by Jefferson and Penn State; at Quentin Riding Academy; 1 day every-other mo.; 2 hrs. per day; 8 hrs. AAGP credit requested; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lewistown Hospital; February 9 - April 12, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; every Wed.; 30 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Lock Haven Hospital; October 20, 1971 - April 19, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; first

and third Wed. except holidays; 30 hrs. AAGP credit requested, fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Meadville; September 1, 1971 - May 3, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS; at Meadville City Hosp.; first Wed. ea. mo.; 18 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Philadelphia; September 15, 1971 - May 17, 1972
Continuing Medical Education Seminars; at Methodist Hospital; 1 day ea. mo.; 2 hrs. per day; 18 hrs. AAGP credit requested; fee = none. Contact John N. Giacobbo, M.D., D.M.E., Methodist Hosp., 2301 S. Broad St., Philadelphia 19143.

Philadelphia; October 13 - December 1, 1971
Recent Advances in Medicine; at Temple; 1 day ea. week; 4½ hrs. ea. day; AAGP credit requested; fee=$75. Contact Albert J. Finestone, M.D., Dept. of Med., Temple, Broad & Ontario Sts., Philadelphia 19140.

Pittsburgh; August 5, 1971 - June 22, 1972
Post Graduate Medical Education Lectures; at St. Margaret Memorial Hosp.; first, second and third Thurs. ea. mo. except July; 1 hr. per day; AAGP credit requested; min. enrollment=30; fee=none. Contact Paul W. Dishart, M.D., D.M.E., St. Margaret Memorial Hosp., 265 - 46th St., Pittsburgh 15201.

Pittsburgh; September 2, 1971 - June 15, 1972
Psychiatry Seminars in Family Practice; at St. Margaret Memorial Hosp.; 1 day ea. week; 2 hrs. ea. day; 32 weeks; min. enrollment 6; AAGP credit requested; fee=$50 for ea. 10-week series. Contact Paul W. Dishart, M.D., D.M.E., St. Margaret Memorial Hosp., 265 46th St., Pittsburgh 15201.

Pittsburgh; July 14, 1971 - June 23, 1972
Post Graduate Medical Education Lectures —Family Practice; at St. Margaret Memorial Hosp.; every Wed.; 1 hr. ea. day; AAGP credit requested; min. enrollment=20; fee=none. Contact Paul W. Dishart, M.D., D.M.E., St. Margaret Memorial Hosp., 265 - 46th St., Pittsburgh 15201.

Pottsville Hospital; September 2, 1971 - June 1, 1972
AMA —A Program of Continuing Medical Education; by Jefferson and Penn State; first Thurs. ea. mo.; 2 hrs. ea. day; 20 hrs. AAGP credit approved; fee=none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Reading; September 28, 1971—May 23, 1972
1971-1972 Continuing Education Program; at St. Joseph's Hosp.; 4th Tues. of ea. mo. except Dec.; 1 hr. ea. day; 8 hrs. AAGP credit approved. Contact Kenneth M. Schreck, M.D., Med. Dir., St. Joseph's Hosp., Reading 19610.

St. Marys; September 26, 1971 - March 26, 1972
Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust); by PMS, Pitt and Western Pa. RMP; at Andrew Kaul Memorial Hosp.; forth Sun. ea. mo. except December; 21 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Sellersville; September 22, 1971 - June 15, 1972
AMA —Continuing Education Program; at Grand View Hosp.; by Hahnemann; 2 hrs. per day; 1 day per mo.; 9 months; 18 hrs. AAGP and ACGP credit requested. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Sharon General Hospital; October 20, 1971 - March 1, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; first and third Wed. ea. mo.; 30 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Somerset Community Hospital; Fourth Tuesday of each month
A Program of Continuing Medical Education; by Western Pa. RMP and the Regional PG Medical Faculty Project of Lee Hospital, Johnstown; 2 hrs. ea. day; 24 hrs. AAGP credit requested ea. year. Contact William W. Ayres, M.D., Pathologist, Somerset Community Hosp. 225 S. Center Ave., Somerset 15501.

Tunkhannock; March 8 - May 10, 1972
Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust); by PMS and Greater Delaware Valley RMP; at Tyler Memorial Hosp.; second Wed. ea. mo.; 9 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Uniontown Hospital; September 22, 1971 - February 23, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; every-other Wed. except Dec. and Jan.; 24 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Wellsboro; September 15, 1971 - March 15, 1972
Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust) by PMS and Susquehanna Valley RMP; at Soldiers and Sailors Memorial Hosp.; third Wed. every-other mo.; 12 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Wilkes-Barre; September 15—October 27, 1971
AMA— Continuing Education Program; at Wyoming Valley Hosp.; by Hahnemann; 3½ hrs. per day; 1 day per week; 6 weeks; 21 hrs. AAGP credit requested, ACGP credit approved; fee=none. Contact Frederick K. Heath, M.D., D.M.E., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Williamsport Hospital; September 10, 1971 - March 10, 1972
AMA — A program of Continuing Medical Education; by Jefferson and Penn State; second Fri. ea. mo. except Jan.; 3 hrs. ea. day; 18 hrs. AAGP credit requested; fee=none. Contact John H. Killough, Ph. D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

HEMATOLOGY

Sayre; July 12, 1972—June 5, 1972
Rotating Specialty Seminar/Hematology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 15 weeks; 15 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

INTERNAL MEDICINE

Abington Memorial Hospital; September 2—December 16, 1971
S-Recent Advances in Internal Medicine; 2 hrs. per day; 1 day per week; 15 weeks; max. enrollment=40 (internal medicine); fee=$30. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Philadelphia; October 6, 1971 - May 31, 1972
AMA — Internal Medicine Reviews; at Hahnemann; 3 hrs. ea. day; 1 day ea. week; 32 weeks; 96 hrs. AAGP credit approved; $175 fee ($50 ea. sub-specialty — Hematology & Medical Oncology, October 6 to November 17; Gastroenterology, November 24, 1971 to February 9, 1972, Dermatology & General Topics, February 16 to April 19; Cardiology, April 26 to May 31). Contact Mrs. Sage Cordell, Asst. Dir. PG Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Pittsburgh; September 13 - October 15, 1971
AMA — Internal Medicine Review Course; by Pitt and Amer. Coll. of Physicians; at Pitt; 3 hrs. a day; 2 day ea. week; 5 weeks; 33 hrs. AAGP credit requested; $50 fee. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt. Scaife Hall, Pittsburgh 15213.

MALIGNANT DISEASE

Reading; Fourth Tuesday ea. month
Tumor Conference; at Community General Hospital. Contact Harold I. Farber, M.D., Dir. Tumor Clinic, Community Gen. Hosp., 145 N. Sixth St., Reading 19601.

NEPHROLOGY

Sayre; September 13, 1971—May 29, 1972
Rotating Specialty Seminar/Nephrology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 9 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Norristown State Hospital; September 13, 1971 - May 8, 1972
Intensive Review of Neurology; 1¼ hrs. per day; 1 day per week; 30 weeks; min. enrollment 8; fee=$100. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

NEUROLOGY

Sayre; August 9, 1971—March 21, 1972
Rotating Specialty Seminar/Neurology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 9 weeks; 9 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

OPHTHALMOLOGY

Abington Memorial Hospital; September 22, 1971—May 22, 1972
S-Recent Trends on Ophthalmology; 1½ hrs. per day; 1 day per mo.; 9 mos. 13 hrs. total; max. enrollment=15; fee=none. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

PHARMACOLOGY

Philadelphia; September 27, 1971 - January 24, 1972
AMA — Experimental Design, Statistics and Fortran; at Hahnemann; 2 hrs. per day; 2 days per week; 15 weeks; 58 hrs. AAGP credit requested; fee=$300. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia General Hospital; September 29, 1971 - May 31, 1972
AMA — Current Concepts in Clinical Pharmacology; by Hahnemann and American Society for Clinical Pharmacology and Therapeutics; 3 hrs. per day; 1 day per week; 35 weeks; 105 hrs. AAGP credit requested; fee=none. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

PSYCHIATRY

Abington Memorial Hospital; September 27, 1971—June 12, 1972
S-Seminar in Psychiatry; 1½ hrs. per day; 2nd and 4th Mon. ea. mo., 10 mos.; max. enrollment=30; fee=none. Contact William H. Mahood, M.D., Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Abington Memorial Hospital; March 7—May 9, 1972
S-Marital Therapy; 2 hrs. per day; 1 day per week; 10 weeks; max. enrollment=20; fee=$50. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Allentown Osteopathic Hospital; September 22 - December 8, 1971
AMA — Adolescence and the Youth Culture; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks; 20 hrs. AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Easton Hospital; September 27, 1971 - June 26, 1972
AMA — Psychiatry in Medical Practice; by Hahnemann; 1½ hrs. per day; 1 day per mo.; 9 mos.; 13½ hrs. AAGP credit requested; fee=none. Con-

:t Paul Jay Fink, M.D., Dir. of Educ. & Training, ipt. of Mental Health Sciences, Hahnemann, 230 Broad St., Philadelphia 19102.

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rristown State Hospital; September 10, 1971 - ay 12, 1972
S — Intensive Review of Psychiatry; 1¼ hrs. r day; 1 day per week; 31 weeks; min. enroll- ent=8; fee=$100. Contact John D. Pruitt, M.D., r., Program for Cont. Educ. for Psychiatrists, rristown State Hosp., Stanbridge & Sterigere s., Norristown 19401.

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rristown State Hospital; October 1 - December 1, 1971
S — Group Therapy; 1½ hrs. per day; 1 day per eek; 10 weeks; min. enrollment=8; fee=$50. ontact John D. Pruitt, M.D., Dir., Program for ont. Educ. for Psychiatrists, Norristown State osp., Stanbridge & Sterigere Sts., Norristown 3401.

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orristown State Hospital; January 7 - February 3, 1972
S — Management of Adolescent Behavorial isorders; 1½ hrs. per day; 1 day per week; 7 eeks; min. enrollment=8, fee=$30. Contact ohn D. Pruitt, M.D., Dir., Program for Cont. Educ. or Psychiatrists, Norristown State Hosp., tanbridge & Sterigere Sts., Norristown 19401.

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lorristown State Hospital; March 3 - May 19, 1972
S — Family Therapy II; 1½ hrs. per day; 1 day er week; 10 weeks; min. enrollment=8; ee=$50. Contact John D. Pruitt, M.D., Dir., Pro- gram for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norris- own 19401.

Philadelphia; September 7, 1971 - June 6, 1972
S/AMA — Advances in Psychiatry and Beha- vorial Sciences; by Institute of Pa. Hosp. and U. of Pa.; at the Institute; 1½ hrs. ea. day; 1 day ea. mo.; 10 mos.; fee=$50. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; September 15 - November 17, 1971
AMA — Sexual Problems in Medical Practice; by Hahnemann; 2 hrs. ea. day; 1 day ea. week; 10 weeks; AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 4 - December 6, 1971
S/AMA — Family Therapy; by the Institute of Pa. Hosp. and U. of Pa.; at Philadelphia Child Guid- ance Clinic; 2½ hrs. per day; 1 day per week; 10 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The In- stitute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 6 - December 8, 1971
S/AMA — Marital Therapy; by the Institute of Pa. Hosp. and U. of Pa.; at Marriage Council of Philadelphia; 2½ hrs. ea. day; 1 day per week; 10 weeks; fee =$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The In- stitute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 6, 1971 - February 16, 1972
AMA — Psychiatric Problems of Children; by Hahnemann; 2 hrs. per day; 1 day per week; 18 weeks; 36 hrs. AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Edu. & Training, Dept. of Mental Health Sciences, Hah- nemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 13, 1971 - May 17, 1972
AMA — Seminars in Psychotherapy: Short-term, Crisis & Supportive Therapies; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks per semi- nar; AAGP credit requested; fee=$150 for 30 weeks, $75 for 10 weeks. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; January 10 - March 13, 1972
S/AMA — Behavior Therapy; by the Institute of Pa. Hosp. and U. of Pa.; at Hospital of U. of Pa.; 2 hrs. per day; 1 day per week; 10 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 10 - February 14, 1972
S/AMA — Psychopharmacology; by the Institute of Pa. Hosp. and U. of Pa.; 1½ hrs. per day; 1 day per week; 6 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychi- atrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 11 - February 29, 1972
S/AMA — Treating Today's Adolescent; by the Institute of Pa. Hosp. and U. of Pa.; 1½ hrs. per day; 1 day per week; 8 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March 22 - May 24, 1972
AMA — Adolescence and the Youth Culture; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks; AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; March 22 - May 24, 1972
S/AMA — Advanced Marital Therapy — Treating Sexual Incompatibility; by the Institute of Pa. Hosp. and U. of Pa.; at Marriage Council of Philadelphia; 2½ hrs. per day; 1 day per week; 10 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The In- stitute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Sayre; July 27, 1971—May 8, 1972
Rotating Specialty Seminar/Psychiatry; at Rob- ert Packer Hosp.; 1 hr. per day; 1 day per week; 10 weeks; 10 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

OTHER COURSES
code

C—Continuous (Consecutive Days)
O—One Day or Less
PG—Postgraduate Traineeship
M—Multiple Sites (Circuit)

ALLERGY

September 6 - October 29, 1971; Philadelphia (repeat February 7 - March 13, 1971 and May 1 - June 23, 1972)
PG/AMA — Clinical Immunology Tutorial Course; at Hahnemann; 7-8 hrs. per day; 40 days; fee = $500. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 4-7, 1971; Pittsburgh
C— Diseases Due to Immune Mechanisms; by Pitt; at Veterans Administration Hosp., 8 hrs. per day; 32 hrs. AAGP and AMA Required credit approved; Fee=$125 ($75 for residents, teaching and research fellows). Contact Leo H. Criep, M.D., Course Director, V.A. Hosp., University Dr. C, Pittsburgh 15240.

ARTHRITIS & RHEUMATISM

Continuous; Philadelphia
PG/AMA — Rheumatology Tutorial Course; at Hahnemann; 6-7 hrs. per day; 2 days per week; 4 weeks; fee = $150. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CARDIOVASCULAR DISEASE

Continous (2 or 3 weeks in each sub-section); Philadelphia
PG/AMA — Tutorial Courses; Fluid and Electro- lyte Metabolism; Hypertension (Clinical & Labora- tory); Dialysis; Cardio-Hemodynamics; Cardiac Care Unit; Electrophysiology; Vector-Electrocar- diography and Cardiovascular Pharmacology; Atherosclerosis and Lipid Metabolism; Phono- Echo; Clinical Cardiology and Cardiovascular Sur- gery; at Hahnemann; 6, 7, 8, or 9 hrs. per day; 10 or 15 days; fee = $300 ea. sub-section. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hah- nemann, 230 N. Broad St., Philadelphia 19102.

September 21 - 25, 1971; Philadelphia
C/AMA — Cardiac Arrhythmias (Pathophysio- logy, Pharmacology and Treatment by Hah- nemann; at Marriott Motor Hotel; 7 hrs. ea. day; 4½ days; 30 hrs. AAGP credit approved; $175 fee. Contact Mrs. Sage Cordell, Asst. Dir., Cont. Educ., Hahnemann; 230 N. Broad St., Philadelphia 19102.

September 27 - 28, 1971; Philadelphia
C/AMA — Current Topics in Cardiopulmonary Disease - 1971; Evolving Concepts in Coronary Ar- tery Disease; by American College of Cardiology; at Temple. Contact Miss Mary Ann McInerny, Dir., Dept. of Cont. Educ., American College of Car- diology, 9650 Rockvill Pike, Bethesda, Md. 20014.

CARDIOVASCULAR DISEASE

October 7-8, 1971; Philadelphia (repeat starting March 16, 1972)
C— Cardiopulmonary Resuscitation Instructors' Training Course; at Emergency Care Research In- stitute; by Pa. Heart Assoc. and Heart Assoc. of Southeastern Pa.; 7 hrs. ea. day; fee=$40. Con- tact Emergency Care Research Inst., 913 Walnut St., Philadelphia 19107.

October 28-29, 1971; Hershey
C— Cardiopulmonary Resuscitation Instructors' Training Course; at Hershey; by Pa. Heart Assoc. and South Central Pa. Heart Assoc.; 7 hrs. ea. day; fee=$40. Contact Royce J. Britton, Prgm. Dir., Pa. Heart Assoc., 2743 N. Front St., Harrisburg 17105.

December 13-17, 1971; Philadelphia
C/AMA — High Blood Pressure, 1971 (26th Hah- nemann Symposium); by Hahnemann; at Sheraton Hotel; 7 hrs. per day; 5 days; 35 hrs. AAGP credit approved; fee = $175. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

March 13-15, 1972; Philadelphia
C/AMA— Non-Invasive Technique in Evaluation of Cardiac Function; at U. of Pa.; by American Heart Assoc., Pa. Heart Assoc. and Heart Assoc. of Southeastern Pa.; fee (for Fellows)— $60. Con- tact Miss Carole Mintz, Dept. of Med. Ed., Ameri- can Heart Assoc., 44 E. 23rd St., New York City 10010.

April 10-21, 1972; Philadelphia
C/AMA — Core Curriculum-Fundamentals and Applied Clinical Cardiology Seminar; by Hah- nemann; 7 hrs. per day; 12 days; 84 hrs. AAGP credit requested; fee = $300. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

July 17-19, 1972, Philadelphia
C/AMA — Bedside Diagnosis of Heart Disease; by Hahnemann; 7 hrs. per day; 3 days; 21 hrs. AAGP credit requested; fee = $125. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hah- nemann, 230 N. Broad St., Philadelphia 19102.

CHEST DISEASES

Continuous (4 weeks in each sub-section); Philadelphia
PG/AMA — Tutorial Courses: Clinical Pulmo- nary Disease; Inhalation Therapy; Pulmonary Physiology; Respiratory Intensive Care; at Hah- nemann; 7, 8, or 9 hrs. per day; 20 days; fee = $350. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 4-15, 1971; Wilkes-Barre General Hospital
December 6-17, 1971; Philadelphia (Hahnemann)
March 14-25, 1972; Allentown Hospital
M/AMA — A Workshop in Respiratory Intensive Care; by Greater Delaware Valley RMP: 2 weeks; 5 days ea. week; 70 hrs. AAGP credit approved. Contact F. R. Johnston, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 24 - 28, 1971; Philadelphia
C/AMA — 37th Annual Fall Scientific Assembly;

American College of Chest Physicians; at Sheraton Hotel; 31 credit hours; Fee: Members = no charge; non-members with M.D. degree prior to 1961 = $65 (armed service or US PHS = $45); non-members with M.D. degree received after 1960 = $45 (armed service or US PHS = $25). Contact Bradford W. Claxton, M.Ed., Dir. Cont. Educ., Amer. Coll. of Chest Phys., 112 E. Chestnut St., Chicago, Ill. 60611.

November 1-12, 1971; Philadelphia (repeat February 28 — March 10, 1972)

PG — Bronchoesophagology; at Temple; $350 fee; planned for chest physicians, thoracic surgeons, anesthesiologists and gastroenterologists. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

November 10, 1971; Franklin

O/AMA — A program of Continuing Medical Education; by Jefferson and Penn State; at Franklin Hospital and Voyager Motor Inn; 3 hrs. AAGP credit approved; fee = $10. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 3-6, 1972; Philadelphia

C/AMA — Pulmonary Care in the Seventies (27th Hahnemann Symposium); by Hahnemann; at Marriott Motor Hotel; 5-6 hrs. per day; 4 days; 25 hrs. AAGP credit approved; fee = $175. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

EMERGENCY MEDICINE

September 15, 1971; Bloomsburg State College

O — Malpractice in the Emergency Room; by PMS; 3 hrs. AAGP credit requested; min. enrollment=40; fee=$10. Contact PMS (Emergency Med. Service), 20 Erford Rd., Lemoyne 17043.

October 4-15, 1971; Philadelphia (repeat February 7-18, 1972 and May 2-13, 1972)

PG/AMA — Emergency Room Tutorial Course; by Hahnemann; 8 hrs. ea. day; 10 days; fee=$400. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

March 11, 1972; Hershey

O/AMA — Emergency Room Techniques; by PMS and Pa. Trauma Committee of ACS; at Hershey; 6 hrs.; min. enrollment=50; fee=$10. Contact PMS (Emergency Med. Service), 20 Erford Rd., Lemoyne 17043.

ENDOCRINOLOGY

September 6 - October 1, 1971; Philadelphia (repeat March 6-31, 1972)

PG/AMA — Endocrinology and Metabolism Tutorial Courses; at Hahnemann, 7-8 hrs. per day; 20 days; fee=$350. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

GASTROENTEROLOGY

April 15, 1972; Hershey

O — Seminar on Gastroenterology; by PMS and Pa. Osteopathic Assoc.; at M.S. Hershey; 6 hrs. AAGP and ACGP credit requested; fee=$100; min. enrollment=20. Contact PMS (PMS-POA Seminar), 20 Erford Rd., Lemoyne 17043.

GENERAL MEDICINE

Continuous; Philadelphia

PG/AMA — Tutorial Courses: Basic General Medicine (7-8 hrs. per day; 60 days; fee=$700); Critical Care Medicine (8-9 hrs. per day; 10 days; fee=$300) at Hahnemann. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

As Requested, 1971; Philadelphia

PG — Acute Care Medicine Fellowship (retraining program for women physicians); by M.C. of Pa.; 6 hrs. per day; 1 yr. duration. Contact Ethel Weinberg, M.D., Assoc. Dean, MCP, 3300 Henry Ave., Philadelphia 19129.

Third Wed. ea. mo.; Aliquippa-Rochester Hospitals (rotation)
Fourth Thurs. ea. mo.; Altoona Hospital
First Tues. ea. mo.; Greensburg (Westmoreland Hosp.)
First Thurs. ea. mo.; Johnstown (Conemaugh Valley Mem. Hosp.)
Second Tues. ea. mo.; Natrona Heights (Allegheny Valley Hosp.)
Last Mon. ea. mo.; Uniontown Hospital
First Wed. ea. mo.; Washington Hospital

M — Diagnosis and Management of Hypertension; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin R. Shapiro, M.D., Project Dir., 501 Flannery Bldg., 3530 Forbes Ave., Pittsburgh 15213.

October, 1971; Altoona
October, 1971; Greensburg
November, 1971; Scranton
November, 1971; Williamsport
January, 1972; Allentown
January, 1972; King of Prussia

M — The Physician and Addictive Disease; by PMS, PAGP, Pa. Dept. of Health and Pa. Dept. of Welfare; 8 hrs. AAGP credit requested; min. enrollment=10, fee=$10. Contact PMS, 20 Erford Rd., Lemoyne 17043.

November 8-11, 1971; Lancaster

C/AMA — Clinical Therapeutics 1971: Emergency Medicine; by PMS, U. of Pa., Temple, M.C. of Pa. and Hershey; at Host Farm Resort Motel; 24 hrs. AAGP credit requested; min. enrollment=25; fee=$25. Contact PMS (Scientific Assembly), 20 Erford Rd., Lemoyne 17043.

December 13-17, 1971; Philadelphia

C/AMA — High Blood Pressure - 1971; by Hahnemann; at Sheraton Hotel; 8 hrs. ea. day; 4½ days; 35 hrs. AAGP credit requested; $125 fee. Contact Mrs. Sage Cordell, Asst. Dir., Cont. Educ., 230 N. Broad St., Philadelphia 19102.

May 4-6, 1972; St. Davids

C — Annual Main Line Conference of Bryn Mawr Hosp.; at Treadway Inn; 2½ days; 15 hrs. AAGP credit approved; fee=$35. Contact Theodore J. Berry, M.D., DME, Bryn Mawr Hosp., Bryn Mawr 19010.

INTERNAL MEDICINE

January 3-7, 1972; Philadelphia

C/AMA — Workshops in the Physiology, Pathophysiology and Diagnosis of Disorders of Electrolyte and Acid-Base Metabolism; by Amer. Coll. of Physicians; at Hospital of the U. of Pa.; Fee: Members and F.A.C.P. =$80, non-members = $125, candidate members and ACP Latin American Fellows = $40. Contact Registrar, Postgraduate Courses, Amer. Coll. of Physicians, 4200 Pine St., Philadelphia 19104.

March 20-24, 1972; Philadelphia

C/AMA — Specifically Treatable Diseases (Emphasizing Pathophysiology and Early Clinical Findings); by Amer. Coll. of Physicians; at Pennsylvania Hosp. and U. of Pa.; Fee: Members and F.A.C.P.=$80, non-members=$125, candidate members and ACP Latin American Fellows=$40. Contact Registrar, Postgraduate Courses, Amer. Coll. of Physicians, 4200 Pine St., Philadelphia 19104.

MALIGNANT DISEASE

October 4-29, 1971; Philadelphia (repeat November 1-26, 1971, February 7 - March 3, 1972, and April 3-28, 1972)

PG/AMA — Hematology and Medical Oncology Tutorial Course; at Hahnemann; 8-9 hrs. per day; 20 days; fee=$400. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

NEPHROLOGY

June 5-7, 1972; Philadelphia

C/AMA — Nephrology for the Practicing Physician; by Hahnemann; at Holiday Inn; 7 hrs. ea. day; 3 days; 21 hrs. AAGP credit requested; $125 fee. Contact Mrs. Sage Cordell, Asst. Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

NEUROLOGY

Continuous (12 weeks in each sub-section); Philadelphia

PG/AMA— Tutorial Courses: Clinical Neurophysiology (2 hrs. per day; 1 day per week; fee=$250); Neuropathology; Adult Neurology; Pediatric Neurology (5-6 hrs. per day; 60 days; fee=$1,000); at Hahnemann. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

PEDIATRICS

September 18-19, 1971; Hershey

C— Selected Pediatric Subjects; by Pa. Chapt., American Academy of Pediatrics; at Hershey Motor Lodge; 3 hrs. ea. day; fee=$5. Contact James J. Reilly, Secy., Pa. Chapt., American Academy of Pediatrics, 3520 Laketon Rd., Pittsburgh 15235.

April 13, 1972; Hershey

O — Maternal and Child Health Institute; by PMS and Pa. Dept. of Health; at M.S. Hershey; 7 hrs. AAGP credit requested; min. enrollment=100, fee=$15. Contact PMS (Matern. Health), 20 Erford Rd., Lemoyne 17043.

May 9-12, 1972; Philadelphia

C — Twenty-first Pediatric Postgraduate Seminar; by Temple; at St. Christopher's Hosp. for Children; 6 hrs. ea. day; 24 hrs. AAGP credit requested; $100 fee. Contact John B. Bartram, M.D., St. Christopher's Hosp. for Children, 2600 N. Lawrence St., Philadelphia 19133.

RADIOLOGY

Continuous; Philadelphia

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obituaries

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Clark D. Hause,** Mahanoy City; Temple University School of Medicine, 1945; age 50; died May 7, 1971. He is survived by his wife, two sons, a daughter, and a brother, Welland Hause, M.D., Decatur, Ill.

○ **Lewis J. Leiby,** Slatington; Jefferson Medical College, 1933; age 64; died April 24, 1971. His wife, a daughter, and three sisters survive him.

○ **Donald Riegel,** Drexel Hill; University of Pennsylvania Medical School, 1920; age 73; died May 8, 1971. Dr. Riegel practised medicine in the Philadelphia area for more than 50 years. He is survived by his wife, three sons one of whom is a Wilmington, Del. physician, Charles S. Riegel, M.D., and a brother.

○ **Stephen F. Seaman,** Allentown; Jefferson Medical College, 1929; age 69; died April 28, 1971. He is survived by his wife, a son, a daughter, two sisters, and two brothers.

○ **Van Burchfield Weber, Jr.,** Saxonburg; University of Pittsburgh School of Medicine, 1933; age 52; died May 2, 1971. His wife, five children, one brother, and his parents survive him.

○ **Meyer Zeltzer,** Erie; St. Louis University School of Medicine, 1928; age 74; died May 7, 1971. He was a member of the American Academy of Abdominal Surgeons and the American Academy of Medical Examiners. He is survived by his wife, two daughters, four sons, one of whom is Paul J. Zelter, M.D. of Connecticut, and a brother.

○ **Daniel Barsky,** Boulder, Colo.; Temple Medical College, 1923; age 73; died May 11, 1971. Information regarding survivors is unknown.

○ **John Dohner Boger,** Lebanon; Medico-Chirurgical College of Philadelphia, 1916; age 82; died May 21, 1971. He was a radiologist and was instrumental in establishing the department of radiology at Good Samaritan Hospital. He is survived by his wife, a daughter, and two sons, J. Beil Boger, M.D., and William M. Bogar, M.D., both of Rochester, N.Y.

○ **Sebastian J. Buonato,** Ardmore; Jefferson Medical College, 1932; died in January of 1971. He was a member of the American College of Obstetricians and Gynecologists. No information regarding survivors is available.

○ **Louis Benjamin Cohen,** Philadelphia; Jefferson Medical College, 1929; age 70; died June 15, 1971. He was chief of the department of ophthalmology at Einstein Medical Center, northern division, and a staff member of Wills Eye Hospital. He is survived by his wife; a son, Ronald Colliver, M.D.; a daughter; and a sister.

○ **Joseph Francis Cunningham,** Philadelphia; Medico-Chirurgical College, 1916; age 85; died March 8, 1971. Survivors are unknown.

○ **Horace F. Darlington,** West Chester; Hahnemann Medical College, 1933; age 63; died May 26, 1971. He was a charter member of the American Academy of General Practice and served as secretary of the Chester County chapter for ten years. He is survived by his wife, a daughter, a son, two sisters, and a brother.

○ **Creedin S. Fickel,** Carlisle; Jefferson Medical College, 1920; age 72; died June 7, 1971. He practiced in Carlisle for fifty years. He is survived by his wife, two daughters, and a son.

○ **Joan Fara Giambalvo,** Philadelphia; Temple University School of Medicine, 1955; age 39; died May 14, 1971. There is no information concerning survivors.

○ **Henry Victor Grahn,** Bala Cynwyd; Jefferson Medical College, 1923; age 79; died June 12, 1971. Survivors include two daughters, a son, and a sister.

○ **Casimar C. Groblewski,** Plymouth; University of Pennsylvania Medical School, 1911; age 84; died May 25, 1971. He is survived by his wife, a daughter, a son, a sister, and two brothers.

○ **Frederick A. Heupler,** Pittsburg; Stritch School of Medicine, Chicago, 1932; age 63; died June 7, 1971. In addition to his wife, he is survived by two daughters and a son, Frederick A. Heupler, Jr., M.D.

○ **Harry Lawrence Highberger,** Herminie; University of Pittsburgh School of Medicine, 1910; age 84; died June 6, 1971. He is survived by his wife and one son.

○ **E. Russell Ingraham,** Masontown; Northwestern University Medical School, 1906; age 89; died June 8, 1971. He was a member of the Radiological Society of North America. A daughter survives him.

○ **Clyde L. Mattas,** Scranton; Jefferson Medical School, 1920; age 74; died May 21, 1971. He was a member of the American College of Physicians and a fellow of the American Geriatric Society. He is survived by his wife, three daughters, a son, and a brother.

○ **Isaac J. Muldawer,** Philadelphia; Medico-Chirurgical College, 1913; age 87; died May 22, 1971. He was a diplomate of the American Board of Pediatrics. Survivors include his wife, two sons, Drs. Milton and Leonard Muldawer, and five sisters.

○ **Elmer J. Saltzman,** Houston; University of Pittsburgh, 1946; age 58; died May 15, 1971. He was a fellow of the American Academy of General Practice. He is survived by his wife, three sisters, and one brother.

○ **David Harlan Schatz,** Philadelphia; Temple University School of Medicine, 1936; age 64; died April 24, 1971. Information concerning survivors is not available.

○ **Troy M. Thompson,** Elizabethtown; Temple University School of Medicine, 1924; age 75; died June 11, 1971. His wife survives him.

○ **Cyrus W. Truxal,** Somerset; Hahnemann Medical College, 1913; age 84; died February 28, 1971. Information regarding survivors is not available.

○ **Maurice J. Ward,** Darby; Jefferson Medical College, 1929; age 69; died May 22, 1971. In addition to his wife, he is survived by two daughters; two sons, one of whom is Maurice J. Ward, M.D., Philadelphia; and a sister.

○ **J. Norman White,** Scranton; Jefferson Medical College, 1904; age 94; died June 6, 1971. He served as a physician and surgeon for over fifty years. His wife and a daughter survive him.

(continued on page 96)

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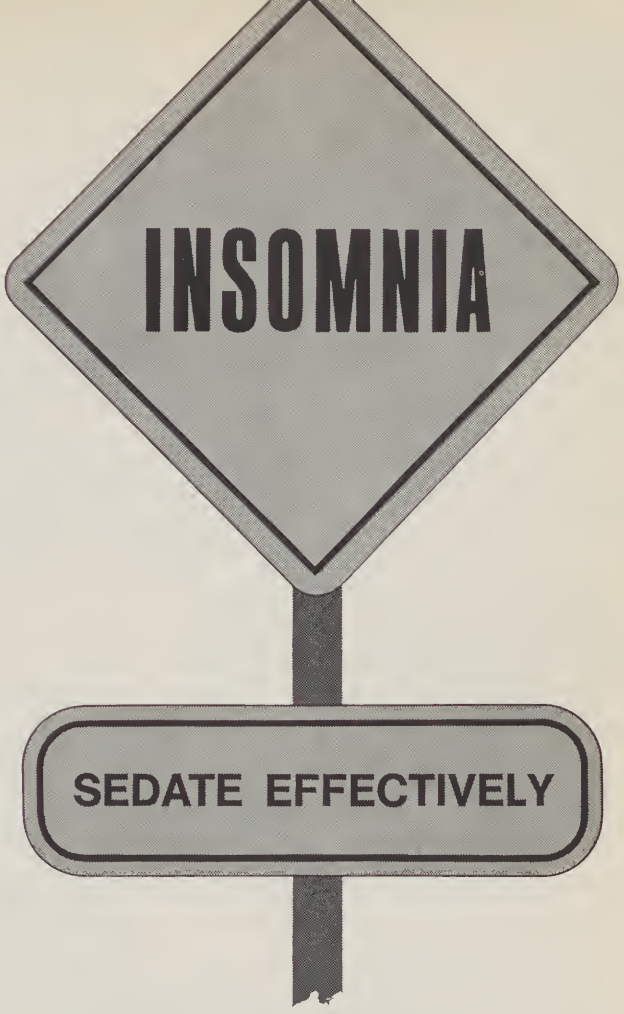

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Thomas A. E. Datz, formerly of Johnstown; Jefferson Medical College; age 46; died May 25, 1971. He practiced surgery in Pittsburgh and in Cambria. His mother and four sons survive.

Alfred A. Ferry, Upper Darby; Temple University School of Medicine, 1917; age 79; died June 5, 1971. He is survived by two daughters and three sons.

Jerry Goosenberg, Woodland Hills, Cal; Jefferson Medical College, 1962; age 34; died June 14, 1971. He was a fellow of the American College of Obstetricians and Gynecologists, who formerly lived in Upper Darby. He is survived by his wife, two daughters, a son, and his mother and father.

George G. Knoll, Philadelphia; Jefferson Medical College, 1908; age 93; died February 5, 1971. There is no information regarding survivors.

Alexander V. Orlando, Sayre; Georgetown Medical School, 1953; age 49; died June 1, 1971. He was a member of the American Academy of General Practitioners and a diplomate of the National Board of Medical Examiners. He is survived by his wife, his parents, two daughters, and a sister.

Joseph J. Repa, Wilkes-Barre; Jefferson Medical College, 1929; age 69; died May 25, 1971. He was a member of the American Thoracic Society who practiced in Oneonta, N.Y. He is survived by his wife, a son, a daughter, a brother, and two sisters.

Eugene A. Ronan, Houtzdale; Georgetown University Medical School, 1936. age 63; died May 16, 1971. Survivors include his wife; two sons, one of whom is William J. Ronan, M.D., Dayton, Ohio; two daughters and two sisters.

Edward E. Woldman, Philadelphia; Ohio State University School of Medicine, 1923; age 74; died June 12, 1971. He was a fellow of the American College of Physicians and the American College of Gastroenterologists. He is survived by his wife, a daughter, a brother, and a sister.

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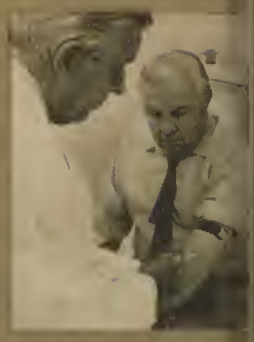

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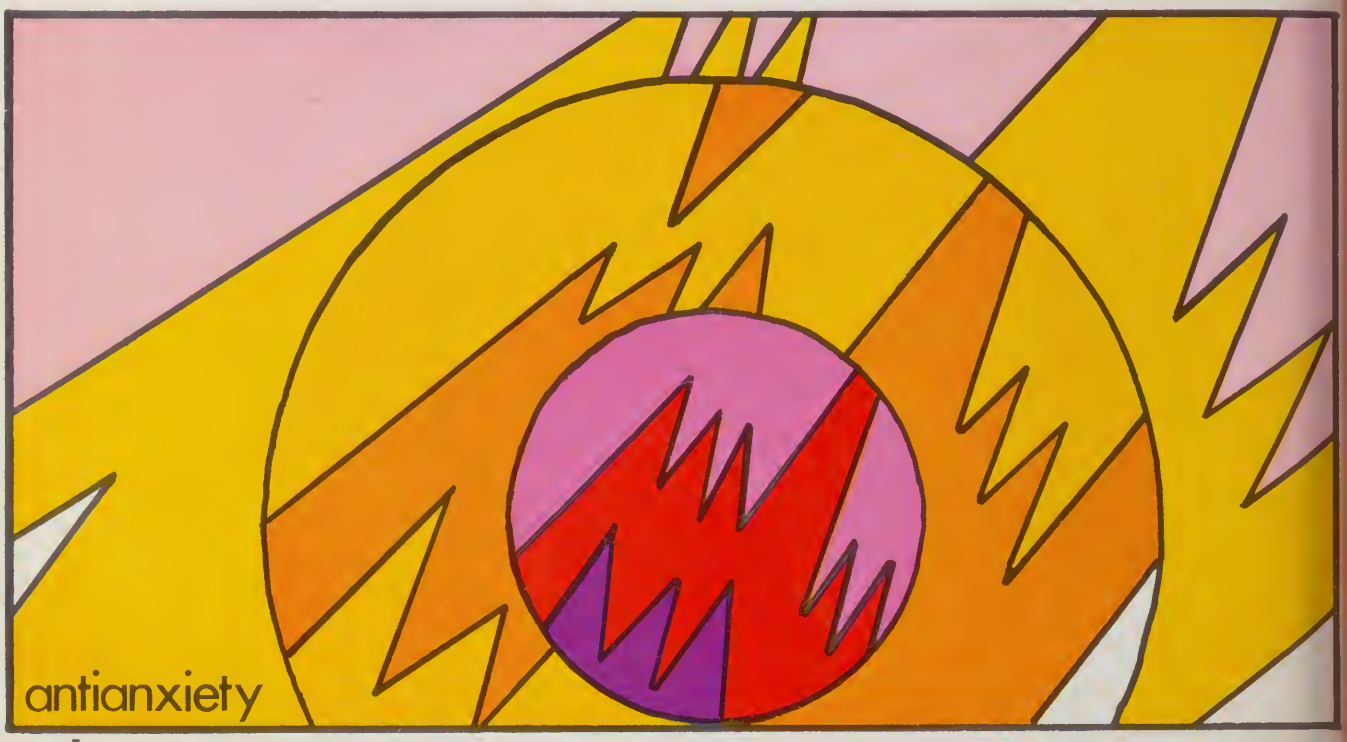

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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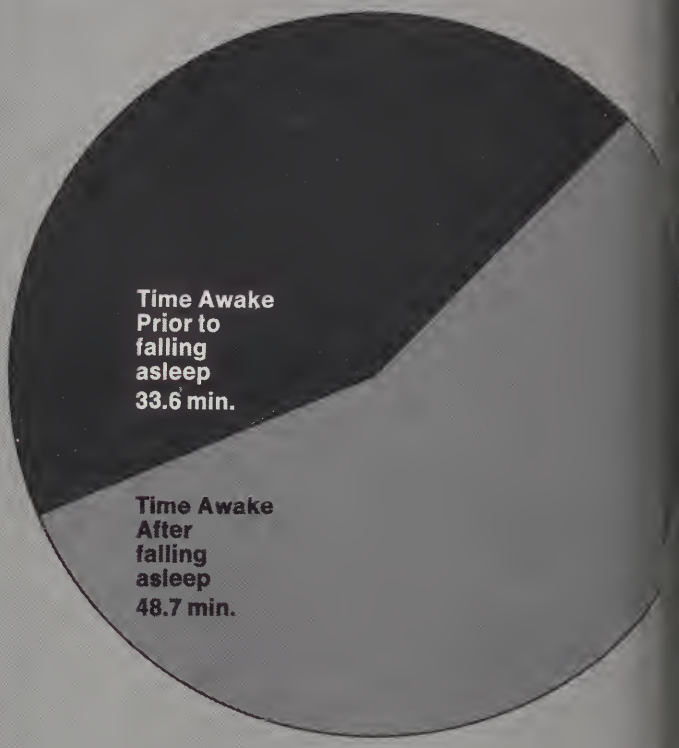
References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

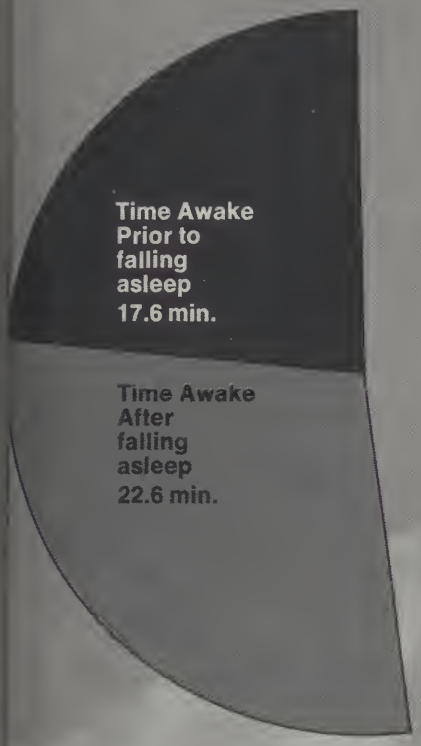
Before Dalmane (flurazepam HCl)



Measurements of sleep in the sleep laboratory are obtained with electroencephalographic, electro-oculographic and electromyographic recordings.

and slept through the night

On
Dalmane
flurazepam HCl)



ge sleep laboratory measurements in cited studies

efer	Before Dalmane	On Dalmane
required to fall asleep	33.6 min.	17.6 min.
time after onset of sleep	48.7 min.	22.6 min.
er of wakeful periods after et of sleep	12.2	8.4
sleep time	420.0 min.	447.5 min.
sleep percent	88.6	94.5

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

Clinical effectiveness as proven in the sleep laboratory

Dalmane®
(flurazepam HCl)

e 30-mg capsule h.s.—usual adult dosage.
e 15-mg capsule h.s.—initial dosage for erly or debilitated patients.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

PENNSYLVANIA MEDICINE

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Journal of the Pennsylvania Medical Society

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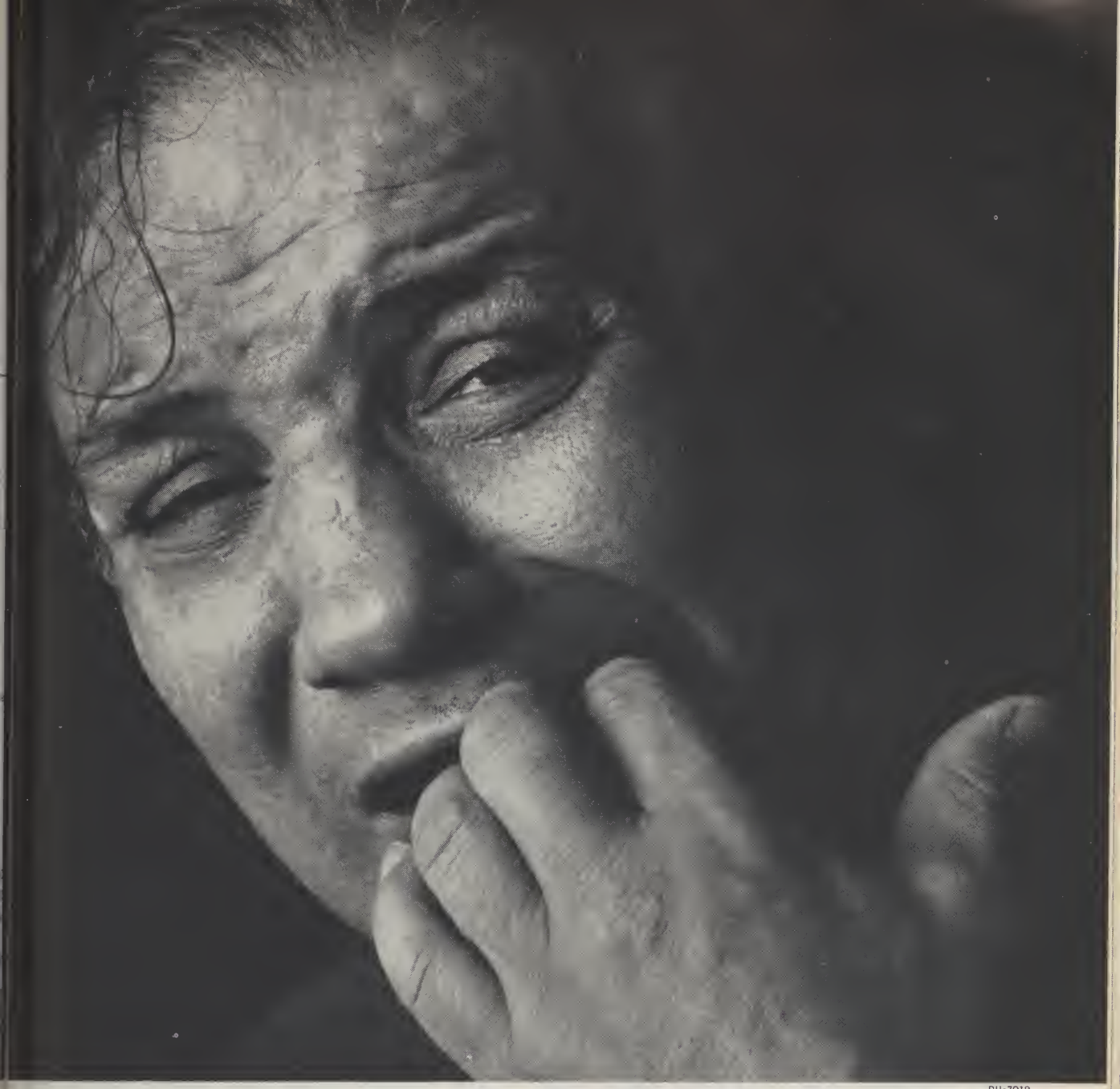

DU-7019

Who's afraid of the big bad enema?

We all are. But Dulcolax is the cure for enemaphobia. It can do almost anything an enema can – except look scary.

Just one suppository usually assures a predictable bowel movement in 15 minutes to an hour. Gone are the tubing, the "accidents", and the bruised egos associated with enemas.

For preoperative preparation, the combination of tablets at night and a suppository the next morning usually cleans the bowel thoroughly. Suppositories may also be particularly helpful when straining should be avoided as in postoperative care.

As with any laxative, abdominal cramps are occasionally noted. The drug is contraindicated in the acute surgical abdomen.

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now...

for the stable adult diabetic who needs higher doses of a reliable oral hypoglycemic...

new DBI®-TD 100 mg.

(phenformin HCl)

timed-disintegration capsules

- a higher dosage strength for use in the overweight, maturity-onset diabetic if diet alone fails
- a biguanide...not a sulfonylurea
- new dosage flexibility
- low patient cost

new DBI®-TD 100 mg.
(phenformin HCl)
timed-disintegration capsules

lowers elevated blood sugar

econdary to its blood sugar lowering effect, BI-TD probably decreases insulin versecretion and thus may help reduce ogenesis and facilitate lipolysis. This may count for the clinically reported reduction weight and lowering of serum cholesterol vels in the overweight and hypercholes- remic diabetic patient.

usually well tolerated

Mainly gastrointestinal side effects may occur. However, as with many drugs, you should keep in mind that higher dosages may increase the incidence. Hypoglycemic reactions are rare when DBI-TD is used alone.

to prescribe DBI®-TD (phenformin HCl) if diet alone fails specify

DBI-TD 50 mg. for the newly diagnosed overweight, stable adult diabetic
DBI-TD 100 mg. for the overweight, adult-onset diabetic who needs higher doses of a reliable oral hypoglycemic

dications: Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary. **Contraindications:** Diabetes mellitus that an be regulated by diet alone; juvenile diabetes that is uncomplicated and well regulated on insulin; acute complications of diabetes metabolic acidosis, coma, infection, gangrene); surgery; severe hepatic disease; renal disease with uremia; cardiovascular collapse, fter disease states associated with hypoxemia. **Warning:** Use during pregnancy is to be avoided. Until adequate data on the effects f DBI on the human fetus are available, such use can be considered experimental. **Precautions: Starvation Ketosis,** which must be ifferentiated from "insulin lack" ketosis, and is characterized by ketonuria in spite of relatively normal blood and urine sugar, may esult from excessive DBI therapy, excessive insulin reduction or insufficient carbohydrate intake. Adjustment of DBI-TD or insulin osage, or supplying carbohydrates, alleviates this state. DO NOT GIVE INSULIN WITHOUT FIRST CHECKING BLOOD AND URINE SUGARS. **Lactic Acidosis:** DBI is not recommended in the presence of azotemia or in any clinical situation that predisposes to sus- ained hypotension that could lead to lactic acidosis. To differentiate lactic acidosis from ketoacidosis, it is recommended that eriodic determinations of ketones in the blood and urine be made in diabetics previously stabilized on DBI, or DBI and insulin, who ave become unstable. If electrolyte imbalance is suspected, periodic determinations should also be made of electrolytes, pH and he lactate-pyruvate ratio. DBI should be withdrawn and insulin, when required, and other corrective measures instituted mmediately upon the appearance of any metabolic acidosis. **Hypoglycemia:** Although hypoglycemic reactions are rare when DBI is used alone, every precaution should be observed during the dosage adjustment period, particularly when insulin or a sulfonylurea has been given in combination with DBI. **Adverse Reactions:** Principally gastrointestinal, occurring more often at higher dosage levels; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, DBI should be immediately with- drawn. Although rare, urticaria and gastrointestinal symptoms following excessive alcohol intake have been re- ported. **Dosage:** 25 mg.-300 mg. daily. **How Supplied:** 50 mg. timed-disintegration capsules, bottles of 100 and 1000; 100 mg. timed-disintegration capsules, bottles of 100 and 500. **Also Available:** DBI tablets 25 mg., bottles of 100 and 1000.

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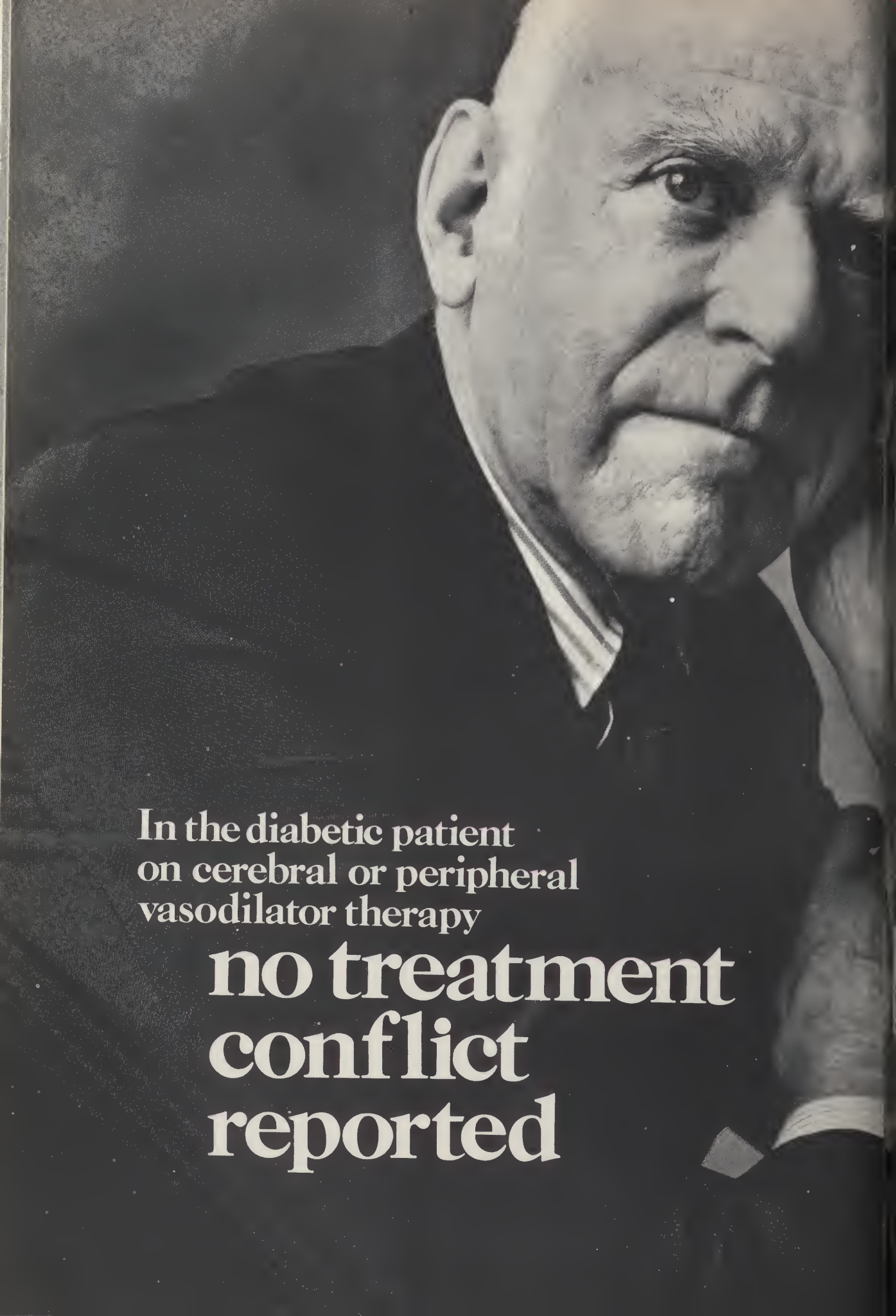
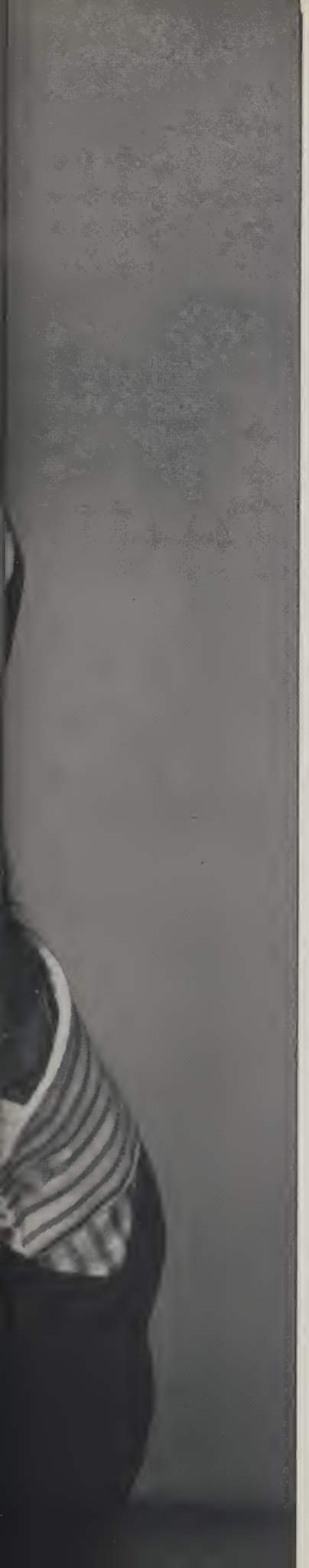

In the diabetic patient
on cerebral or peripheral
vasodilator therapy
no treatment
conflict
reported



VASODĪLAN®
(ISOXSUPRINE HCl)
the compatible vasodilator

- no interference with diabetic control ...does not alter carbohydrate metabolism.[1]
- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.
- complications in the treatment of coronary insufficiency, hypertension, peptic ulcer, glaucoma and liver disease have not been reported.

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[2-5] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[3,5] and observation of clinical improvement.[2,4]
Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODĪLAN tablets, isoxsuprine HCl 10 mg, and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories.

References: (1) Samuels, S. S., and Shaftel, H. E.: J. Indiana Med. Ass. *54*:1021-1023 (July) 1961. (2) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. (3) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (4) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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At last-an answer to your malpractice protection anxiety.

An insurance program sponsored and supported by the PMS

The Pennsylvania Medical Society has been increasingly concerned about the problems faced by its members in securing and retaining professional liability insurance. There has been a growing tendency for insurance carriers to arbitrarily cancel, or not renew, professional liability insurance contracts for reasons entirely beyond the physician's control.

The obvious answer had to be a program, sponsored by the Pennsylvania Medical Society, designed to provide its members with *long term* coverage, adequate limits, at the best possible cost, in addition to giving the Society an opportunity to participate in the policy-making and administration of the program.

Such a program, more progressive and comprehensive than any that has been made available to any medical group, now exists. It is being underwritten by the Argonaut Insurance Company, a well established, "A+AAAA" rated casualty insurance carrier with assets in excess of $180,000,000 and considerable experience in the medical liability field. The exclusive, full-time administrator of the program is Parker & Co. Inc. of Pennsylvania, one of the country's leading insurance brokerage firms.

In review, the major points of the program are:

1. The Pennsylvania Medical Society has entered into an agreement with the Argonaut Insurance Company to administer the program through Parker & Co., Inc. of Pennsylvania.
2. The Argonaut Insurance Company will be bound to make this program available for a *minimum of five years. No* other carrier has offe such an agreement.
3. The Society participates throug Professional Liability Insura Commission consisting of tw members. The Commission will the ultimate authority in app stemming from disputes betw member insureds and will work close conjunction with the local trict committees.
4. No member's application will be clined except by the *joint deci* of the PMS Commission and Argonaut Insurance Company.
5. Full liability coverage of $100,0 for each claim with an annual ag gate limit of $300,000 with ex limits up to $1,000,000 availa Coverage *is* available for interns, idents and physicians' and surge assistants.
6. Rates are competitive with ot major writers of professional lia ity insurance in Pennsylvania.
7. There is no requirement tha member purchase ancillary in ance coverages (homeowners, a etc.) in order to participate.

This program offers PMS meml a unique opportunity to stabilize t professional liability insurance co age on a long term basis. Howeve broad based, high degree of mem ship involvement is essential to m this program a success. Please fill t the coupon indicating your interes participating in the PMS endorsed gram when your present cove expires.

Argonaut Insurance Companies

Mail to:
Parker & Co., Inc. of Pennsylvania
1616 Walnut Street, Philadelphia, Pennsylvania 19103
Attention: Mr. A. John Smither, Vice President

Name_____

Office Address_____

Telephone No. _____

Medical Specialty_____

Date your professional liability insurance expires _____

Present Carrier _____

I am interested in participating in the PMS Professional Liability Insurance Program. Please send me an application. ☐

OUSE OF DELEGATES TO CONVENE

onday, Oct. 4 in the ballroom of ull report on the actions of the ssues of PENNSYLVANIA MEDICINE.

The opening session of the House of Delegates will be at 7:30 p.m., the Pittsburgh Hilton Hotel. A House will appear in subsequent

EDICAL CARE FOUNDATION DUE FOR HOUSE ACTION

tion, approved in concept by the 1970 PMS House ue for action at the 1971 Annual Session of the House. A special eference committee will be considering a foundation report from he Council on Medical Service which includes background material, valuation of the foundation concept, a number of explanatory charts, nd the proposed articles of incorporation and bylaws. The PMS oard of Trustees authorized a $30,000 project contribution for the 971-72 fiscal year of the Foundation, and the Allegheny County Med- cal Care Foundation announced a $5,000 contribution to the proposed MS Foundation. A federal grant, a Pennsylvania Blue Shield commit- ent of services, and a similar offer from Western Pennsylvania egional Medical Program have made possible the research and devel- pment phase. The Foundation's operational phase will adapt the indings and mechanisms to the health service plans offered to con- umers by the Pennsylvania Medical Care Foundation as alternatives o present methods of delivering and financing health care. Ulti- ately, in addition to providing the public with options to present ealth care financing mechanisms, the Foundation will seek to qual- fy as a professional standards review organization and as a health aintenance organization. Other goals include providing the State ociety with resources to assist the private health insurance in- ustry in developing effective cost control mechanisms and to com- lement the design of postgraduate programs in medical education oordinated or sponsored by the Pennsylvania Medical Continuing Ed- ication Institute. The Institute is another State Society-sponsor- d body authorized by the 1970 House of Delegates. PENNSYLVANIA EDICINE will carry complete reports in subsequent issues.

The proposed PMS Medical Care Found- of Delegates, is

OISE POLLUTION LIMITS ASKED

evels of specific products, such as trail bikes, power lawn mowers, aps for toy guns, etc., with the suggestion that noise level safe- y standards be set and that manufacturers be required to label ach item with the noise-time tolerance before it can be sold in ennsylvania. There are several bills pending in the Congress which ollow the same approach and would set standards for the entire ountry. On the state level, Senate Bill 678 contains some of the ociety's request but would not require product labeling. It would ontrol community noise at levels far below levels of proven earing loss.

The State Society has asked the state government to examine noise

PHARMACISTS FIGHT VD

Pennsylvania pharmacists are being asked by their state association president, LaRue Lunger, to participate in a campaign to expose the public, particularly young people, to "plain talk" information on venereal disease, its prevention and its consequences. Besides the printed material which drug stores are asked to display, pharmacists have been asked to have information regarding the nearest VD treatment facility in the event they are asked for this information.

HAHNEMANN INTRODUCES PA PROGRAM

Hahnemann Medical College this fall introduced a new two-year training course for the physician's assistant (PA). It is the first such program in Pennsylvania and the sixth in the nation, according to a college spokesman. Ten students are currently enrolled. They will have a year of academic study and a nine-month preceptorship under a practicing physician.

RESIDENTS: PAY OR GRANT?

Two Arkansas physicians serving residencies argued that their renumeration as residents was a tax-free grant, filed a suit for refund in U.S. District Court and won their case before a jury. A Texas resident tried the same thing in U.S. Tax Court and lost his case. Tax Court cases are decided by a judge, District Court cases by a jury. Even a number of court decisions reversing IRS rulings will not change the rulings. IRS frequently sticks with the rulings that it knows would be reversed if the taxpayer appeals to District Court. Thousands of resident physicians now are expected to seek tax refunds in District Courts.

WASHINGTON REACTIVATES

Congress returned to business following the summer vacation, after having passed 127 bills which were signed into law. Few of these were health-related. The Senate Finance Committee will consider the amendments to the Social Security Act already passed by the House. It is expected the committee will include in the amendments the Professional Standards Review Organization proposal (the Bennett amendment). Congressman Wilbur D. Mills, chairman of the House Ways and Means Committee, has announced public hearings on national health insurance as soon as the committee completes consideration of President Nixon's economic proposals. This alters a previous schedule which would have postponed the hearings until after the first of the year.

AMPHETAMINE STUDY UNDER WAY

The Board of Trustees has requested that the Council on Education and Science make a recommendation concerning the growing number of county medical societies which have asked physicians to restrict the prescribing of amphetamines to the few medical conditions where they are the drugs of choice. The voluntary restrictions are aimed at reducing the number of such drugs which find their way into abuse area

DR. HARTMAN ACTING CHAIRMAN

John F. Hartman, M.D., Erie, has been named acting chairman of the State Board of Medical Education and Licensure, following the resignation of Charles B. Hollis, M.D., Philadelphia. The State Society has submitted a list of physicians to Governor Shapp and has asked him to select from it to fill several vacancies on the State Board.

George P. Rosemond new PMS president

MARY L. UEHLEIN

In the well-ordered life of George P. osemond, M.D., who becomes the 22nd president of the Pennsylvania ledical Society on October 5, 1971, nly the place of his birth was nplanned.

His mother was visiting in Hillsboro, .C., when he entered the world on ugust 23, 1910. He grew up in the mily's home town of Kinston, N.C., nd attended the University of North arolina for undergraduate work. After arning a B.S. degree in 1932, he came Temple University School of Medine and received a degree in medicine 1934. He has been associated with emple and its hospital ever since, and ays of the move, "I'm a thoroughly ransplanted Pennsylvanian. When I reire my home will be here."

Always Wanted Medical Career

"I can't remember a time when I idn't want to practice medicine," Dr. Rosemond declares. He was exposed rom childhood to the career of a hysician because two uncles and two reat uncles were doctors. Dr. Rosemond's sister followed him to Temple University mainly because he was in medical school there, and she, too, stayed on, married a Philadelphian, and lives in suburban Philadelphia.

George Rosemond's father died shortly after his graduation from medical school, and his mother, too, became a Pennsylvanian by adoption. She lived in the Philadelphia area for fifteen years prior to her death last year. There still are many relatives and cousins "by the dozen" in North Carolina.

When he was in medical school George Rosemond met his wife, Jean Mason, then just 14, through her uncle, William N. Parkinson, M.D., dean of the medical school at Temple for thirty years. The Rosemonds have been married for thirty-four years and have a daughter, Linda, married to Howard Buzzard, Jr. They are typically proud grandparents of David Mason Jr., 4, and infant granddaughter, Charlyn Elizabeth.

Lifetime Devoted to Surgery

Following his internship, George Rosemond stayed at Temple for a three-year residency in general surgery, during which time he earned an M.S. degree in his special field. He is a member of a group practice in general surgery, with offices at the hospital, and has been teaching surgery at Temple since 1939. Since 1963 he has been professor of surgery and chairman of the department. A fellow of the American College of Surgeons, he is also a diplomate of the American Board of Surgery and of the Board of Thoracic Surgery. Author of over 100 papers, several of which have appeared in PENNSYLVANIA MEDICINE, he is called on to lecture at scientific meetings throughout the world. Despite his contribution of time and effort to various medical organizations, he maintains a regular schedule in the operating room, and has devoted himself to the American Cancer Society, serving in many capacities, including president of the Philadelphia Division. The medical organizations of which he is an active member number over twenty, and he serves a number of voluntary agencies in an active capacity.

George Parrott Rosemond has a firm belief that physicians must be involved in all aspects of health care. "I don't object to some form of national health insurance, but I am convinced that physicians, through foundations such as the Pennsylvania Medical Care Foundation, must assume the responsibility for solving the numerous complications of Health Maintenance Organizations. Doctors must be in on decision-making in all matters of health care— pre-paid plans, peer review and national health insurance— and we can only do this through our societies on the state, county and national levels."

Dr. Rosemond pointed to the PMS-sponsored malpractice insurance plan as an example of how doctors can solve problems related to the practice of medicine by becoming involved directly.

He suggested that there must be a

Continued

RUSSELL B. ROTH, M.D., Erie, who is serving his third term as speaker of the House of Delegates of the American Medical Association (AMA), is the first announced candidate for president-elect of AMA in 1972. He served on AMA's Health Care Financing Committee and helped to frame the association's Medicredit health insurance plan. Dr. Roth is a member of the American Urological Association, the American Association of Clinical Urologists, the American College of Surgeons, and the Academy of International Medicine. He has served as chairman of the Board of Trustees of PMS and speaker of PMS House of Delegates.

Dr. Rosemond new president

way now to solve the problem of maldistribution of physicians. To achieve this he said, "I would recommend consideration of all possible ways, including the proposed government-sponsored draft, by a committee of the State Society."

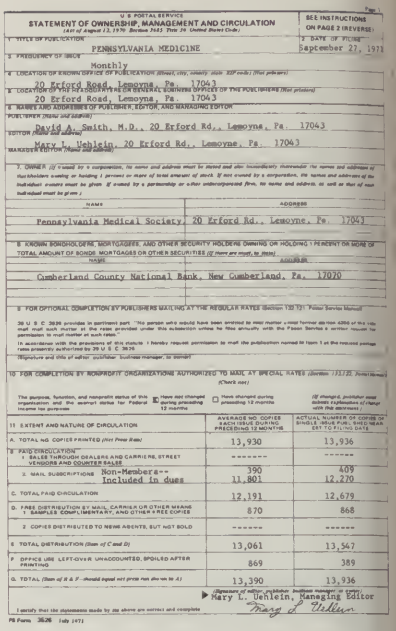
Activities Mirror Philosophy

Dr. Rosemond became active in medical society affairs early in his career and has devoted years of service. He has held numerous positions, including the presidency, in the Philadelphia County Medical Society, and has been a delegate for many years from that county. He served as chairman of the delegation from 1967 through June, 1970. His activities reflect his basic philosophy of physician involvement for the good of all people.

He holds to the philosophy that preventive health care— improving the environment, solving the housing dilemma in both rural and ghetto areas, improving nutrition of people throughout the world— will go a long way in solving the health care crisis, both in financing and in the physician shortage.

What does this activist in medical affairs, busy surgeon who is becoming known world-wide for his work in breast cancer, teacher, writer, and lecturer do to relax? He swims before breakfast every morning possible, loves the open country, particularly around his home in Chester County, enjoys bird-watching, golf, and travel. He admits however, to having little time for relaxation, and says, "When we travel, it usually is related to a medical meeting."

A dynamic leader, George P. Rosemond brings to the Pennsylvania Medical Society presidency a firm belief that never was the need greater for such an organization than today and a philosophy which guides his activities— that quality health care can be made possible for all, with the leadership of physicians through their organizations.



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(Signature of editor, publisher, business manager, or owner)
Mary L. Uehlein, Managing Editor
Mary L. Uehlein

I certify that the statements made by me above are correct and complete

PS Form 3526 July 1971

Florida licensing by endorsement

For the first time in history, the Board of Medical Examiners of Florida may issue licenses by endorsement to practice medicine and surgery in Florida. An amendment to the Medical Practice Act of Florida, enacted by the 1971 legislature, allows issuance of licenses by endorsement to those M.D.'s who have been certified by the National Board of Medical Examiners or the Federation Licensure Examination (FLEX) within a period of eight (8) years preceding the date of application for licensure by endorsement.

Since the effective date is September 1, 1971, this means that an M.D. must have been certified by the National Board of Medical Examiners since September 1, 1963, in order to initially be eligible for licensure by endorsement. As far as other state licensure examinations are concerned, this amendment only applies to those states who use the Federation Licensure Examination (FLEX) as their licensure examination.

A physician who receives a license by endorsement in Florida must practice in the state within a period of three years for a minimum period of one year. If he does not do this the license will become null and void. Service in the armed forces is exempt during these three years, but internship or residency time is not exempt.

FDA establishes packaging rules

Standards for child-resistant containers for aspirin and drugs containing aspirin have been proposed in the FDA's first action under the poison prevention packaging act.

The regulation would require that 85 percent of a 200-child test group could not open the container on the first attempt and further that 80 percent must fail even after having been shown how to open it.

The agency is expected to extend the packaging standard for other household products possibly including prescription drugs in the future.

Postgraduate day set in Pittsburgh

The American Gastroenterological Association (AGA), the American Academy of General Practice, and the University of Pittsburgh School of Medicine will cosponsor a Regional Postgraduate Day on Saturday, October 23, 1971, at the Pittsburgh Hilton Hotel.

Several Pennsylvania doctors are among the participants: Wayne W. Peternel, M.D., chief of gastroenterology at Mercy Hospital, Pittsburgh; and Larry C. Carey, M.D., associate professor of surgery and Lee M. Hershenson, M.D., clinical associate professor of medicine, both of the University of Pittsburgh School of Medicine.

A format to encourage registrant participation will replace the formal lecture method. Tuition fee including lunch is $50 (doctors in training $15). The American Academy of General Practice has approved 6 hours of credit. Send registration to AGA Postgraduate Courses, Box 190, McLean, Virginia 22101.

Malpractice program offers exclusive benefits

The PMS-endorsed malpractice insurance program underwritten by the Argonaut Insurance Company and administered by Parker & Company of Pennsylvania offers a variety of exclusive benefits to physicians in the state but the plan is not a true group program, PMS officials point out.

R. Robert Tyson, M.D., chairman of the PMS Commission on Professional Liability Insurance, says some physicians incorrectly look on the program as a "group plan" and then ask questions such as, "What's the premium for an obstetrician in my region?"

There isn't a fixed premium for members of a given specialty in a region, Dr. Tyson points out, because the endorsed program is not a group plan and deliberately so. He said that PMS rejected the group plan concept because uniform rates for a given specialty in a region result in the good risks paying dollar penalties for the actions of the poor risks in the group.

Rates Individually Determined

Instead, the PMS-endorsed program rates are individually determined so that the good risks benefit and the poor risks have an added incentive to correct any conditions that may be contributing to their poor-risk rating.

Dr. Tyson stressed that although it would be impossible to publish the premium rates for such an individual determination program, physicians will find that the rates compare favorably with those of other malpractice insurance underwriters. In some individual instances, the PMS program rates are lower and, generally speaking, in virtually all instances they are no higher than for comparable coverage weighed against its comparable risks.

Offers Long-Range Solution

If there is no significant immediate financial advantage to changing to the PMS-endorsed program, should physicians leave their present carrier?

Dr. Tyson says the program offers a long-range solution to the problem of securing and retaining adequate insurance coverage. The company has agreed to underwrite the Society's membership for a minimum of five years during which it is bound to uphold the provisions of the individual contracts unless individual non-renewal is concurred in by the State Society. The underwritten members have agreed to work on loss prevention by education, counseling, and evaluation of problems.

Over the past few years, physicians have been finding fewer and fewer firms offering professional liability insurance and even those they could find became increasingly restrictive and selective. Physicians with no malpractice claims against them have found their coverage not renewed for nebulous reasons. In addition, even the longest contracts were for only one year.

Since the PMS-endorsed program came into existence, Dr. Tyson said there are indications that other malpractice underwriters have become a little less restrictive and he concludes that this is due to the direct competition of the PMS-endorsed program.

For those who choose to be insured by Argonaut under the PMS plan, Dr. Tyson emphasizes that once a member's application is accepted he can relax for at least five years, secure in the knowledge that his policy can't be "non-renewed" without his having the right to appeal to the Society for review on his behalf. He points out that this five-year coverage security feature has not been offered by any other carrier writing professional liability insurance in Pennsylvania.

Society Plays Major Role

What influence does the State Society have in the program? Dr. Tyson said the program is unique in providing for the Society's participation on behalf of its members in those areas of administration which, although of vital and direct importance to the insured physician, are generally held by the insurance industry as being sacrosanct.

For instance, the Society has complete review of all statistical information relative to classification and rate-making purposes, such as premiums written and earned, investment income, claims reserves and claims payments and loss figures. The Society also is involved in underwriting decisions, including a review in all cases where Argonaut refuses to provide coverage for a State Society member, intends to terminate coverage for a member, or proposes to restrict coverage based on the specific specialty of a member. The final decision in such instances rests with the State Society.

Naturally, rates inevitably reflect enrolled risks and it is to the benefit of the enrolled members of the State Society to have those responsible for underwriting decisions exercise great care in making those decisions. Acceptance of a preponderance of "poor risks" inevitably would push premiums up.

Supervising the State Society's responsibilities in the operation and administration of the program is a "Commission on Professional Liability Insurance" with a membership that includes a representative of each of the twelve Councilor Districts in the state plus grass roots committees in each of the Councilor Districts with both an underwriting decision and claims settlement responsibility.

Any members with questions are invited to call the State Society or Mr. A. John Smither, Vice President of Parker & Company in Philadelphia.

Preceptorships offered at Medical College of Pa.

The Medical College of Pennsylvania is offering a limited number of preceptorships for physicians, including general practitioners and specialists, during the 1971-72 academic year.

Programs conducted at the college hospital are available in the following areas: internal medicine, pediatrics, obstetrics and gynecology, surgery, radiology, and psychiatry.

The preceptorships are individually planned to be most relevant to the practitioner's educational needs. Activities include clinics and rounds, with patient responsibility as applicable.

Applicants are being invited to the college in order to work with the faculty on designing appropriate programs.

AMA reports on 'physician's assistant' statu

The Department of Health Manpower of the American Medical Association has issued a report on the current status of the "physicians assistant" concept.

Although a total of 2,498 educational programs have been accredited by the American Medical Association covering assistants, technicians, and technologists, no uniform mechanism or standard for national recognition has been established.

Specific job descriptions for assistants in orthopedics, urology, internal medicine, and family practice have been developed by their respective medical specialty organizations, and the AMA is now in the process of developing criteria for accreditation of educational programs in these categories.

A listing of current training programs not yet accredited by the AMA has been distributed. Institutions where programs are being offered are on file with the Council of Education and Science at Pennsylvania Medical Society headquarters, 20 Erford Rd., Lemoyne 17043.

Concurrently, the American Association for Medical Assistants (AAMA) has revised curriculum standards for associates and assistants, so that the bas one-year curriculum leads to a medic assisting certificate and the two-ye program offering advanced cours leads to an associate degree. Further i formation may be obtained by co tacting AAMA, One East Wack Drive, Chicago, Ill. 60601.

ACP announces post grad courses

The American College of Physicians has announced its 1971-72 educational program in the form of forty regional scientific meetings and twenty-nine postgraduate courses. The continuing education courses will be held in cooperation with medical schools, hospitals, and other institutions.

Edward C. Rosenow, Jr., M.D., Philadelphia, executive vice-president of the college, says that newly instituted self-assessment programs will enable internists and practitioners in related fields to plan their continuing education more effectively.

The Eastern Pennsylvania regional meeting will be held in Philadelphia November 5-6. Further information may be obtained from Francis J. Sweeney, Jr., M.D., Thomas Jefferson University Hospital, 11th and Walnut Streets, Philadelphia 19107.

The Tri-State regional meeting, which includes Western Pennsylvania, will be held in Pittsburgh November 12-13. Contact Donald W. Bortz, M.D., 517 First National Bank Building, Greensburg 15601, for further information.

HEW calls for licensure moratoriu

The transmittal to Congress of the report on "Licensure and Related Health Personnel Credentialing" has been announced by Health, Education, and Welfare Secretary Elliot L. Richardson. This report identifies major problems associated with licensure, certification, and accreditation of allied health personnel and makes specific recommendations as previously requested by Congress.

The first recommendation urges a two-year moratorium on the enactment of legislation establishing new categories of health personnel. A second recommendation, dealing with national examinations, urges the use of such tests already extant and the develop ment of new proficiency exams fo other categories subject to licensure.

The report encourages increased liai son among health licensing boards an governmental agencies and the inclu sion of consumer representatives o licensing boards. It also urges con tinued competency requirements an new concepts of institutional licensure

A congressionally-chartered public corporation will be considered t promote national coordination o accreditation. A feasibility study for a national system of certification for ap propriate categories of health personne will be made.

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Health Department announces appointments

The appointment of Edward R. Goldman as deputy commissioner of mental retardation and acting commissioner has been announced by Secretary of Public Welfare Helene Wohlgemuth.

He was formerly deputy executive director of the Philadelphia Association of Retarded Children and a member of the Mental Retardation Community Council of Philadelphia.

He succeeds Donald H. Jolly, M.D., who has been named director of research and training in the office of mental retardation.

Mr. Goldman holds a Master's degree in government administration from the University of Pennsylvania.

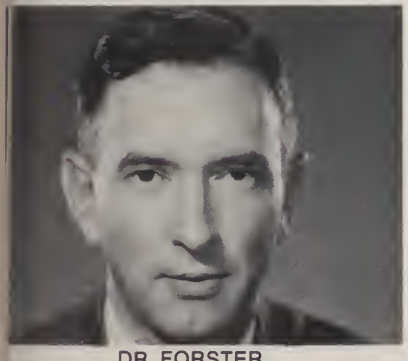
Mrs. Wohlgemuth also has announced the acceptance of the application of Alfred C. Kraft, M.D., commissioner of medical services and facilities in the department, for appointment effective Oct. 1, to the position of medical research director at the South Mountain Restoration Center, in Franklin County. The position is being established to upgrade state services for the aged.

Dr. Kraft, in applying for the new position, said other responsibilities in his present position divert the time and attention he wants to give to the development of the restoration center concept. He came to the department in 1965 to develop such a program. He has been in his present position since Nov. 15, 1968.

The Secretary also has announced the appointment of Benjamin P. Clark, M.D., formerly superintendent of White Haven School and Hospital, Luzerne County, to the post of superintendent of Laurelton State School and Hospital, Union County. The White Haven post temporarily is being filled by Charles M. Pohl, M.D., assistant superintendent of clinical services.

Chest Physicians honor state M.D.

The American College of Chest Physicians will honor four medical teachers and researchers for their work in the cardiovascular and respiratory fields at the college Convocation on October 27 during the Third Scientific Assembly in Philadelphia.



DR. FORSTER

A Pennsylvanian, Robert E. Forster, M.D., St. Davids, chairman of the department of Physiology and Isaac Ott professor of physiology at the University of Pennsylvania School of Medicine, is one of the recipients.

Dr. Forster is a member of the cardiovascular study section and of the General Clinical Research Center committee of the National Institutes of Health and the National Advisory Heart Council.

Questions about economic freeze? Answers are available locally

Questions or complaints about the wage-rent-price freeze are being handled by existing field offices of the Internal Revenue Service under the direction of the U.S. Office of Emergency Preparedness. There are twenty-one such offices in Pennsylvania with the Philadelphia one at 401 N. Broad Street, Pa. 19108, serving as a regional office. The other twenty offices, listed alphabetically, are:

Allentown, 118 North 9th Street, Pa. 18102; Altoona, 1109 Twelfth Street, Pa. 16601; Beaver Falls, 1501 Eighth Avenue, Pa. 15010; Bethlehem, 68 East Elizabeth Avenue, Pa. 18018; Chester, Fifth and Market Streets, Pa. 19013; Erie, 121 West Tenth Street, Pa. 16501; Greensburg, East Gate Shopping Center, Pa. 15601; Harrisburg, 228 Walnut Street, Pa. 17101; Johnstown, Room 237, Post Office Building, Pa. 15901; Lancaster, 46 South Duke Street, Pa. 17082; McKeesport, 337 Shaw Avenue, Pa. 15132; Norristown, 1711-A Markley Street, Pa. 19401; Pittsburgh, 1000 Liberty Avenue, Pa. 15222; Pottsville, 420 North Centre Street, Pa. 17901; Reading, 525 Franklin Street, Pa. 19602; Scranton, 125 North Washington Avenue, Pa. 18514; Washington, 70 East Beau Street, Pa. 15301; Wilkes-Barre, Main and South Streets, Pa. 18703; Williamsport, 322 Locust Street, Pa. 17701; and York, 2801 Eastern Boulevard, Pa. 17402.

Diabetes report revealed

Results of a twelve-month statewide diabetes detection program have been reported by Mildred C.J. Pfeiffer, M.D., director of the division of chronic diseases of the Pennsylvania Department of Health.

A total of 173,500 were tested with 1,461 possible victims being referred to private physicians for further study.

AABB sets standards for donor blood

The American Association of Blood Banks (AABB) has adopted new standdards effective October 1, 1971, to require the testing of donor blood and blood components for the hepatitis-associated antigen.

John B. Henry, M.D., Syracuse, N.Y., president of AABB, said that costs for the improvement in the quality of transfusion service may amount to several million dollars. He added that "ways probably will be found to increase the presently 20 to 30 percent effectiveness of these tests in detecting carriers of hepatitis."

The requirement states that "all donor blood shall be tested for hepatitis-associated antigen using reagents and technics specified by the Division of Biologics Standards, or proven to have equivalent sensitivity and specificity. The blood shall not be used for transfusion unless the test is non-reactive." However, blood may be transfused before completion of the test under certain emergency conditions.

At the association's annual meeting in Chicago in September a workshop, exhibits, and scientific papers on the tests will be presented.

Clinical Virology

Clinical Virology: The Evaluation and Management of Human Viral Infections, by Robert Debré and Josette Celers, 871 pp., 125 illus., $38, Philadelphia: W.B. Saunders Co., 1970.

As stated in the Foreword, this book brings together in one volume comprehensive information pertaining to clinical virology. Although the majority of the 58 contributors are French, the authors have called on 13 contributors from 8 other countries. The arrangement of the material in the book by the anatomic system involved provides a sound basis for assistance to the clinician in the management of individual cases. By the same token, this arrangement provides an orderly approach to the disease entities for the medical student and the epidemiologist. In the introduction, one will find a basic science course in virology, which the reviewer, a non-virologist, finds exceedingly helpful.

Tables (74) and figures (120) are used to summarize in an orderly fashion many of the specific points made in the texts of the various chapters. For example, in the introduction to the section on respiratory viral infections are tabl and figures which summarize the clinical syndromes wi which certain viruses have been shown to be associated.

Specific detailed instructions as to the collection of a propriate specimens for laboratory studies are included ve helpfully in each chapter devoted to infections responsib for a single anatomic system. There are extensive bibliogr phies to and including reports published in 1967, with a fe references as recent as 1969.

The rapidity of advances in virology makes it almost in possible for any publication not to be out of date by th time it is published. Although there are a few newer deve opments which are not included in the book, it does provid an excellent comprehensive source of information for mo of what presently is established about viral infections.

W.D. Schrack, Jr., M.D
Division of Communicable Disease
Pennsylvania Dept. of Healt

EVENT:	J. Herbert Nagler Annual Symposium sponsored by the Philadelphia Academy of General Practice
DATE:	Sunday, November 7, 1971 4 p.m.
PLACE:	Holiday Inn City Avenue and Schuylkill Expressway Philadelphia, Pa.
PROGRAM:	Specific Program to be announced.
AAGP Credit;	Four Hours Applied

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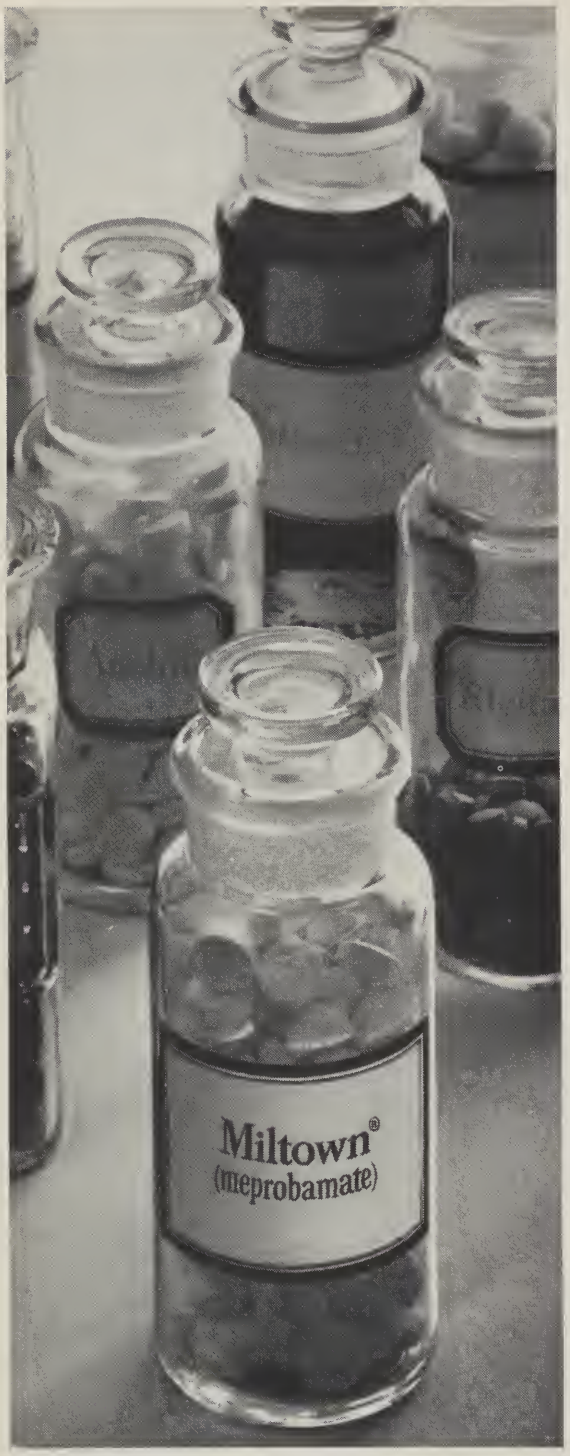

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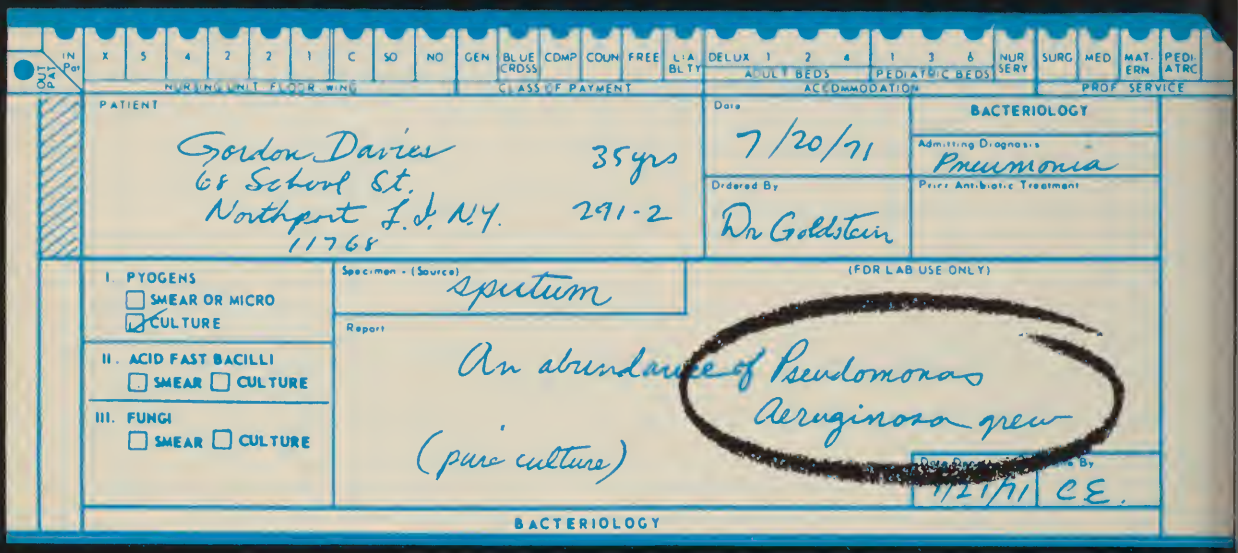

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PATIENT

Gordon Davies 35 yrs
68 School St.
Northport L.I. N.Y. 291-2
11768

Date: 7/20/71

BACTERIOLOGY

Admitting Diagnosis: Pneumonia

Ordered By: Dr Goldstein

Prior Antibiotic Treatment:

I. PYOGENS
☐ SMEAR OR MICRO
☑ CULTURE

II. ACID FAST BACILLI
☐ SMEAR ☐ CULTURE

III. FUNGI
☐ SMEAR ☐ CULTURE

Specimen - (Source): sputum

(FOR LAB USE ONLY)

Report:

An abundance of Pseudomonas aeruginosa grew

(pure culture)

Date Reported: 7/21/71 By: C.E.

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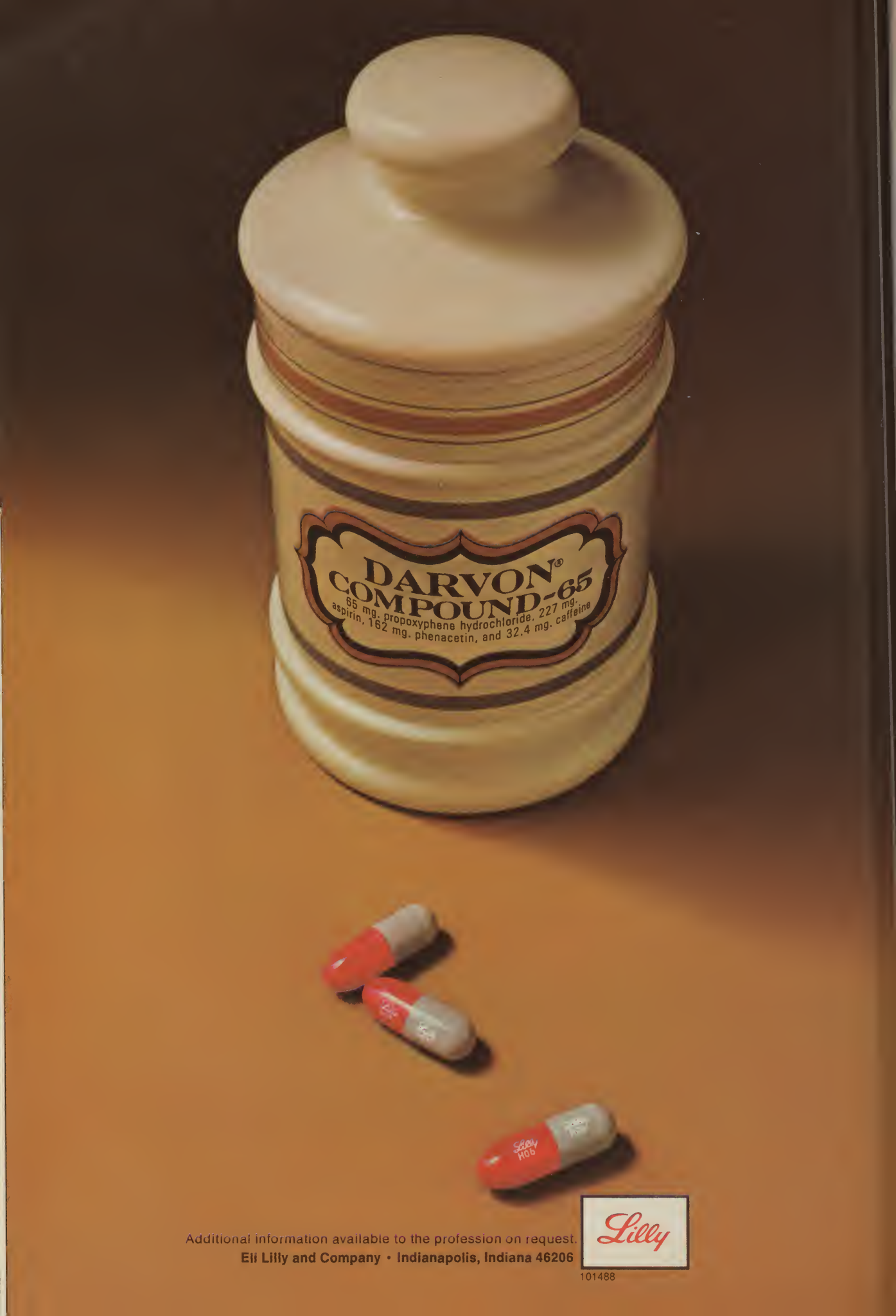
Although PYOPEN (disodium carbenicillin) is indicated primarily in Gram-negative infections, its activity against Gram-positive organisms should be kept in mind when both Gram-positive and Gram-negative organisms are isolated (see Actions). **Note:** During therapy, sensitivity testing should be repeated frequently to detect the possible emergence of resistant organisms. **Actions:** Organisms found to be susceptible *in vitro* include: Gram-Negative Organisms-*Ps. aeruginosa, Proteus mirabilis, Pr. morganii, Pr. rettgeri, Pr. vulgaris, E. coli, Enterobacter* species, *Salmonella* species, *Hemophilus influenzae,* and *Neisseria* species. Gram-Positive Organisms-*Staphylococcus aureus* (nonpenicillinase-producing), *Staph. albus, Diplococcus pneumoniae,* Beta-hemolytic streptococci, and *Streptococcus faecalis.* Some newly emerging pathogenic strains of *Herellea, Mima, Citrobacter,* and *Serratia* have also shown *in vitro* susceptibility. Not stable in the presence of penicillinase. *Klebsiella* species are resistant. Some strains of *Pseudomonas* have developed resistance fairly rapidly. **Contraindications:** Known penicillin allergy. **Warnings:** Serious and occasional fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, appropriate therapy should be instituted and discontinuance of disodium carbenicillin therapy considered, unless the infection is life threatening and only amenable to disodium carbenicillin therapy. The usual agents (antihistamines, pressor amines, and corticosteroids) should be readily available. **Usage in Pregnancy:** Safety for use in pregnancy has not been established. **Precautions:** As with any other potent agent, it is advisable to check periodically for organ-system dysfunction, including renal, hepatic, and hematopoietic systems, during prolonged therapy. Emergence of resistant organisms, such as *Klebsiella* species and *Serratia* species, which may cause superinfection, should be kept in mind. Each gram contains 4.7 mEq sodium; in patients where sodium restriction is necessary, such as cardiac patients, periodic electrolyte determinations and monitoring of cardiac status should be made. Observe patients with renal impairment for bleeding manifestations and adhere strictly to dosage recommendations. If bleeding manifestations appear, discontinue antibiotic and institute appropriate therapy. As with any penicillin preparation, the possibility of an allergic response, including anaphylaxis, may occur, particularly in a hypersensitive individual. **Administration:** Intramuscular injections should be made well within the body of a relatively large muscle (not into the lower and mid-third of the upper arm), and aspiration is necessary to help avoid inadvertent injection into a blood vessel. May be given by either intravenous injection or intravenous infusion. After reconstitution with Sterile Water for Injection unused portions should be discarded after 24 hours if stored at room temperature, or after 72 hours if refrigerated. **Adverse Reactions:** *Hypersensitivity Reactions*—Skin rashes, eosinophilia, pruritus, urticaria, drug fever, and anaphylactic reactions. *Gastrointestinal Disturbances*—Nausea. *Hemic and Lymphatic Systems*—Hemolytic anemia, thrombocytopenia, leukopenia, neutropenia, in uremic patients receiving high doses (24 gm/day), hemorrhagic manifestations associated with abnormalities of coagulation tests, such as clotting and prothrombin time. *Hepatic and Renal Studies*—SGOT and SGPT elevations have been observed, particularly in children. To date, no clinical manifestations of renal disorders have been demonstrated. *Central Nervous System*—Convulsions or neuromuscular irritability could occur with excessively high serum levels. *Local Reactions*—Pain at the site of injection, sometimes accompanied by induration. Vein Irritation and Thrombophlebitis—particularly when undiluted solution is injected directly into the vein. **How Supplied:** Available in 1 Gm. and 5 Gm. vials.
Before prescribing or administering, see package circular or PDR.



Additional information available to the profession on request.

Eli Lilly and Company • Indianapolis, Indiana 46206

Lilly

101488

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

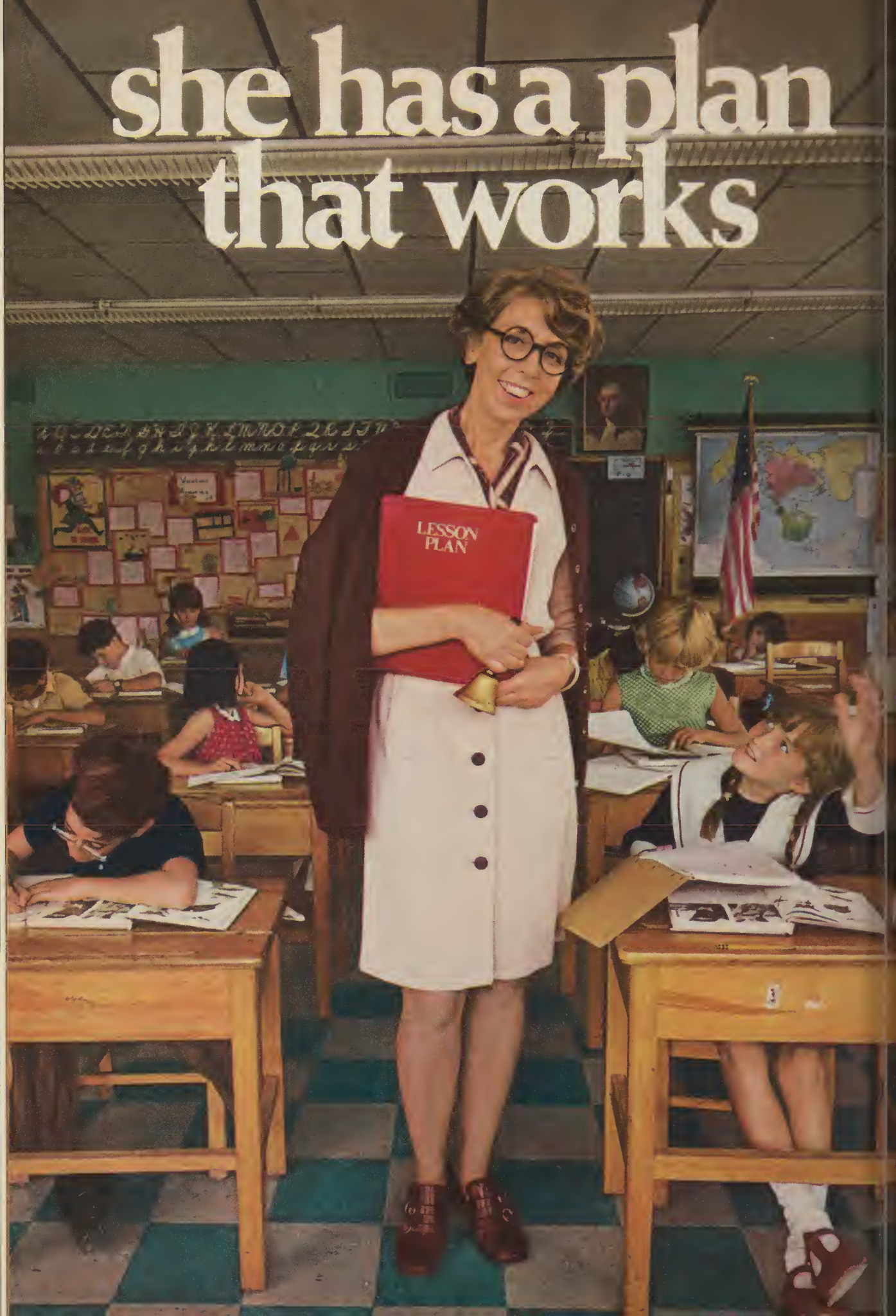
Supplied: Bottles of 100 capsules.

SK&F

SK&F Co., Carolina, P.R. 00630
a subsidiary of Smith Kline & French Laboratories

DZ-108

she has a plan that works



She has a plan that works.

She has one plan for the class. And they really respond.

She has another plan just for herself. A medication plan for her hypertension. And she's also responding beautifully.

More than just another antihypertensive, Ser-Ap-Es can be a whole medication plan for living with hypertension.

Does it get good marks for comfort?

Excellent. Because Ser-Ap-Es controls blood pressure effectively, dosage of each component is lower than if prescribed alone, usually minimizing side effects. However, side effects may occur (see prescribing information).

Designed with the kidney in mind?

Hydralazine maintains or increases renal blood flow.

And the brain too?

Hydralazine also relaxes cerebral vascular tone. And reserpine has beneficial calming action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

Practical on a teacher's salary?

Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits…

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

C I B A

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

a plan for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

INDICATIONS: All cases of hypertension except the mildest and the most severe.

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

Hydralazine: Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Reserpine: The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydralazine: Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

Hydralazine: Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage.

Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop.

Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Reserpine: Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

Hydralazine: Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

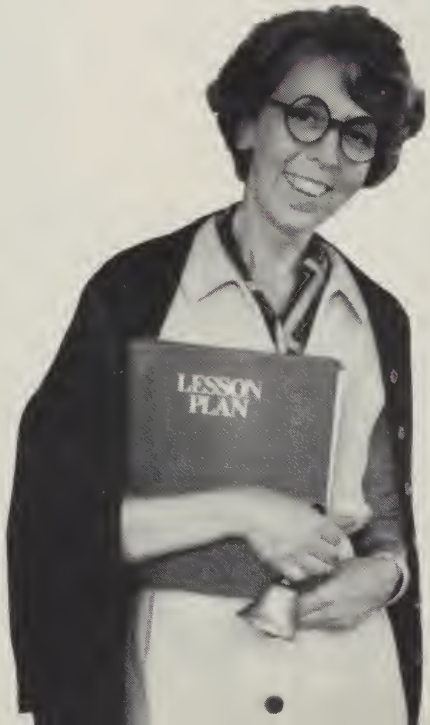
Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE: One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

SUPPLIED: *Tablets* (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901 —2/4624-1 17



she has a plan that works for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

CIBA

You don't build a medical building, or a hospital, a group practice clinic or extended care facility without a particular kind of expertise.

We aren't doctors or hospital administrators, or social scientists, but if you were to take a survey of the various kinds of knowledge and experience our staff can bring to bear on a health facility building project or problem, we think you'd be quite impressed with the range and depth.

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INLAND STEEL DEVELOPMENT CORP.

A Subsidiary of Inland Steel Urban Development Corp.
315 West Gortham Street, Madison, Wisconsin 53703 Phone (608) 257-5675

Facts about Loridine® I.M.
cephaloridine

Facts about activity

Loridine is indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed below.* It is active against the following organisms in vitro:

Beta-hemolytic and other streptococci (many strains of enterococci, e.g., *Streptococcus faecalis*, are relatively resistant)
Staphylococci, both coagulase-positive and coagulase-negative (some strains of staphylococci are resistant to cephaloridine)
Pneumococci
Gonococci
Hemophilus influenzae
Escherichia coli and other coliform bacteria
Klebsiella
Proteus mirabilis

Loridine also has demonstrated activity against *Treponema pallidum* in experimental syphilis studies in animals.

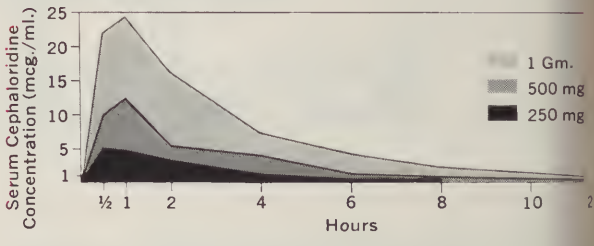
All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine. However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *H. influenzae*, *Pr. mirabilis*, *Esch. coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

*Loridine is indicated in the treatment of gonorrhea when penicillin is not considered the drug of choice.

Facts about dosage

In adults, most infections of moderate severity caused by susceptible organisms respond to Loridine in dosages ranging from 500 mg. to 1 Gm. every eight hours (1.5 to 3 Gm. daily). This use of lower dosages helps prevent drug accumulation. The more susceptible infections have been treated with 250 to 500 mg. every eight hours.



Mean Serum Cephaloridine Concentrations after I.M. Administratic Single Doses (250 mg. to 1 Gm.) to Normal Human Volunteers (S. Eighteen Subjects per Group). (Modified from Currie, J. P.: Cepha dine: Pharmacology and Toxicology, Postgrad. M. J., 43 [Suppleme 22, 1967.)

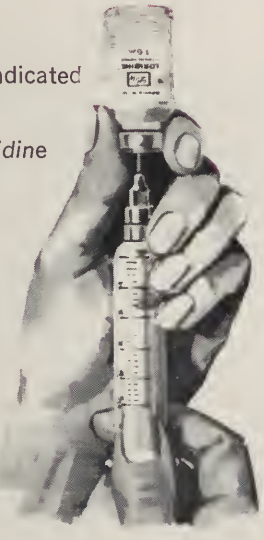
Peak serum levels have been noted with Loridine wit one-half to one hour following I.M. injection. The mean peak serum levels obtained in normal subjects one hou after a 500-mg. I.M. dose ranged from 12 to 22 mcg. per ml. in separate studies. Administration every six to eight hours permits adequate concentrations to be maintained. In order to avoid excessive serum levels (which could possibly result in damage to the kidney tubules), recommended dosages should not be exceed In adult patients without azotemia who have mildly reduced renal function manifested by slight to modera transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, th *maximum* recommended dosage is 1 Gm. every twelve hours during the period of reduced function.

acts about administration

e following guidelines for therapy with
idine are recommended.

fore Administration of Loridine

1. Establish susceptibility of the pathogen.
2. Determine patient's renal status; Loridine is contraindicated in azotemia.



ring Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status —urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit dosage to 4 Gm. daily for adults (100 mg. per Kg. for children—not to exceed adult dosage). Usual adult dosage range: 1 to 3 Gm. daily.
5. In patients with impaired renal function *before* treatment, reduce daily dosage and keep them under close observation for changes in function. In nonazotemic patients with mildly reduced renal function manifested by slight to moderate, transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the *maximum* recommended dosage (adults) is 1 Gm. every twelve hours during the period of reduced function.
6. In patients who develop impaired renal function or whose preexisting impairment becomes worse *during* treatment, discontinue therapy.

Since Loridine is relatively painless on I.M. injection, it is well accepted by patients.

There is clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins; therefore, Loridine should be used with great caution in patients with known penicillin allergy. Instances of patients who have had severe reactions to both drugs, including death from anaphylaxis, have been reported.

Loridine® I.M.
cephaloridine

Lilly

101553

(Please turn page for prescribing information.)

Loridine® I.M.
cephaloridine

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The p sibility of this complication seems to greater in seriously ill patients given m than recommended doses. Acute tubu necrosis has been found in affected tients coming to autopsy. Rare cases nausea and vomiting have occurred. P in association with intramuscular inject was noted in less than 3 percent of tients. In only one patient in a series 623 was the route changed on this accou Phlebitis at the site of intravenous inj tion has been rare.

Administration and Dosage: *Importan* Before administering Loridine, see pa age insert for details on dilution.

Intramuscular Injection—Loridine usually injected into a large muscle ma

The usual adult dosage for many inf tions of moderate severity is 500 mg. 1 Gm. three times a day at equally spac intervals. Milder and more susceptil infections have been treated with 250 500 mg. given two or three times a d More severe infections may be treat with 500 mg. to 1 Gm. four times a d A single 2-Gm. dose is recommended the treatment of acute gonorrhea. Ea syphilis may be treated with 500 mg. tc Gm. daily for ten to fourteen days.

Although some clinical experience w high doses for life-threatening conditio has been reported, it has been shown th excessive dosages (above 4 Gm. dail may cause serious nephrotoxic reactior For this reason, Keflin® (sodium cephal thin, Lilly) may be preferred when dos larger than 4 Gm. daily are considered f life-threatening situations. If more than Gm. of cephaloridine is injected daily, t patient should be under close clinic observation for changes in renal functi or be hospitalized. In addition, reduc dosage should be employed in patier with known or suspected renal impairmer

In children, a daily total of 30 to 5 mg. per Kg. (15 to 25 mg. per pound) body weight, given in divided doses, h been found effective for mild to mode ately severe infections. A daily total of 1(mg. per Kg. (50 mg. per pound) of bo weight (not to exceed recommended adu doses) may be needed for very seve infections.

Intravenous Injection—In the presenc of extremely serious infections (such bacteremia) or when any infection seen overwhelming, intravenous administratic may be indicated.

Total daily dosages are the same as wi intramuscular injection. For very susce tible organisms, 500 mg. to 1.5 Gm. p day may suffice; for less susceptib organisms and for serious infections, 2 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (ceph loridine, Lilly), 500 mg., 5-ml. siz rubber-stoppered; 1 Gm., 10-ml. siz rubber-stoppered. [08214

Additional information available to the profession on request.

Eli Lilly and Company
Indianapolis, Indiana 462(

101553

m.d.'s in the news

The Milton S. Hershey Medical Center of Pennsylvania State University has announced several new appointments. **William A. Weidner, M.D.**, has been named the first professor and chairman of radiology. He is a diplomate of the American Board of Radiology, a fellow of the American College of Radiology, a member of the Radiological Society of North America and of the American Society of Neuroradiology. He came to Hershey from the University of Oklahoma where he was professor of radiology and associate professor of medicine. A second appointment is that of **Frederick B. Garner, M.D.**, who has been appointed assistant professor of pediatrics. He was chief of pediatrics at the U.S. Public Health Service Hospital in Norfolk.

The University of Pittsburgh School of Medicine has promoted **Klaus M. Bron, M.D.**, to professor of radiology from assistant and associate professor. Dr. Bron is also director of vascular radiology at Presbyterian-University Hospital, Pittsburgh, and a consultant in vascular radiology to Children's Hospital, Magee-Womens Hospital, and the VA Hospital, all of Pittsburgh.

Hahnemann Medical College and Hospital has named **Henry L. Price, M.D.**, Philadelphia, professor and chairman of its newly formed department of anesthesiology, which was previously a division of the department of surgery. He was formerly professor of anesthesiology at the University of Pennsylvania Medical School and at Temple University School of Medicine.

Friends Hospital, Philadelphia, has selected **Jan W. Dieff, M.D.**, of Wayne, as senior staff psychiatrist. He was chief of adult services at the Montgomery County Mental Health Center from 1965-69 and medical director of the Pottstown Area Mental Health Center in 1970.

York Hospital has named **Philip L. Roseberry, M.D.**, York, associate coordinator of the Family Practice Center, York Hospital's three-year postgraduate education program for family practice residents. One of the second year students in the program, **William E. Noller, M.D.**, has won the Mead Johnson $1,200 Award for his graduate education in family practice.

Westmoreland Hospital has named **Pascal D. Spino, M.D.**, Greensburg, as president of the medical staff. He is also a member of the medical staff and instructor in pediatrics at Children's Hospital, Pittsburgh.

Geisinger Medical Center has named as a new associate **Kenneth E. Quickel, Jr., M.D.**, Harrisburg. He is associate in internal medicine, specializing in endocrinology.

William A. Buchheit, M.D., Philadelphia, and Reverend Seraphin J. Conley, Catholic chaplain, have joined the staff on rotation of S.S. Hope, now in Kingston, Jamaica.

Louis A. Soloff, M.D., Philadelphia, professor of medicine and consultant in cardiology at Temple University Health Sciences Center, has been awarded the first Blanche P. Levy Distinguished Service Professorship in recognition of a faculty member who has made significant contributions to the university and the community in his field.

Hartwig Kuhlenbeck, M.D., Ph.D., Philadelphia, was named emeritus professor of anatomy at the Medical College of Pennsylvania. Dr. Kuhlenbeck plans to spend his retirement completing the final two volumes of a five-volume series entitled "The Central Nervous System of Vertebrates." The first three volumes of the series have already been published.

Robert D. Strauss, M.D., Abington, has joined the staff of Allentown General Hospital and Sacred Heart Hospital in Allentown. He will continue on the teaching staff at Temple University Health Sciences Center as an instructor in diseases of the ear, nose, and throat and will practice privately in Allentown.

Herbert Silverstein, M.D., former assistant professor at the Massachusetts Eye and Ear Hospital, Harvard University, has moved to Philadelphia and will be in practice with Drs. David Myers, Woodrow D. Schlosser, Robert J. Wolfson, and Eugene N. Myers. He has joined the staff of Presbyterian-University of Pennsylvania Medical Center.

Jerome Miller, M.D., Philadelphia, of J.F. Kennedy Memorial Hospital, won honorable mention at the AMA meeting in Atlantic City for his exhibit entitled "Corticosteriod Therapy in Allergic Diseases: Three-Pronged Approach."

Stanley Druckenmiller, M.D., Lansford, has been honored by the Panther Valley Chamber of Commerce with presentation of the Chamber's Outstanding Citizenship Award. Dr. Druckenmiller recently retired after serving his community for fifty-eight years.

The Heart Association has announced election of officers in several divisions. The Southeastern Pennsylvania division elected **John Helwig, Jr., M.D.**, Glenside, chief of the cardiovascular section of Germantown Hospital, as president and **Peter T. Kuo, M.D.**, Bala Cynwyd, as president-elect., In the Northcentral Division, **Francis P. Sayers, M.D.**, Selinsgrove, was elected chairman of the board. The Northwestern division reported the selection of **Joseph G. Piroch, M.D.**, Meadville, for the presidency. He is an internist and cardiologist who will conduct a cardiac screening program to study 70,000 males aged 25 to 50 in the chapter area. The Pennsylvania Highlands Heart Association elected **Paul R. Wollslayer, M.D.**, Meyersdale, as its president for the coming year.

William R. O'Brien, M.D., Gladwyne, was installed as president of the Philadelphia Psychoanalytic Institute recently. Dr. O'Brien is chief of the Medical College of Pennsylvania (MCP) psychiatric section as well as clinical associate professor of psychiatry and neurology. New president-elect of the institute is **Robert C. Prall, M.D.**, Merion, clinical professor of child psychiatry and director of the MCP psychiatry residency training program.

Fred H. Harrison, M.D., Connellsville, retired on July 1 after practicing for fifty-five years. He served for many years as otolaryngologist at the Connellsville State Hospital. Dr. Harrison is a life member of the American Academy of Ophthalmology and Otolaryngology, the Pacific Coast Oto-Ophthalmological Society, and the American College of Surgeons.

PENNSYLVANIA MEDICINE cardiovascular brief

Anesthesia in Patients with C-V Disease Part 1

James M. Fenstermacher, M.D., Director of Anesthesiology, Reading Hospital, Reading, Pennsylvania, is questioned by William G. Leaman, Jr., M.D.

What are the effects of anesthetics on the cardiovascular system?

All potent anesthetic and hypnotic agents have a direct myocardial depressant action. However, stimulation of the sympathetic nervous system by inadequate analgesia, hypercarbia or hypoxia will counter, at least transiently, the depressant effects of anesthetic agents. On the other hand, this sympathetic stimulation may precipitate cardiac arrhythmias, especially in the presence of reduced serum potassium or digitalis overdosage. Most potent anesthetic agents are primarily vagolytic, thus exposing the heart to autonomic imbalance with sympathetic dominance, if not overactivity. A generalized vasodilation and reduction in the venous return associated with halothane, methoxyfluorane, and narcotic tranquilizer technics decrease cardiac work, primarily by lowering the peripheral resistance. The venous return then may be augmented by an infusion of 5 percent dextrose in lactated Ringer's solution. In this manner the cardiac output is maintained and organ perfusion is adequate.

What is the effect of the anesthetic on other organs and organ systems?

Almost all anesthetic technics are associated with a reduction in renal and hepatic blood flow. Cardiac and pulmonary function are so closely related that the anesthesia may lead to a disturbance in perfusion and ventilation of the lungs, as well as an increase or decrease in pulmonary vascular resistance.

Will you comment on the technics we should observe in the preparation of the cardiac patient for anesthesia?

Judicious sedation of all cardiac patients prior to operation is a "must." Anxiety markedly increases cardiac work, can precipitate angina pectoris and adds to the drug load necessary to induce anesthesia. The use of relatively small doses of hydroxizine and meperidine one hour prior to the induction of anesthesia usually gives us a quiet patient without excessive metabolic depression.

What about the use of spinal anesthesia in cardiac patients?

Low spinal anesthesia (T8 or below), using relatively small doses of tetracaine in dextrose is very convenient, safe, and well tolerated. This type of anesthesia is good for low abdominal (hernia and related) problems. It is also useful in urogenital and lower extremity orthopedic surgery that can be performed in the supine or lithotomy position. Spinal anesthesia offers the greatest extent of anesthesia for the lowest total drug load.

Will you comment further on positions suitable for the cardiac patient at operation?

As a general rule, patients suffering from cardiac or cardio-pulmonary disease do not tolerate the prone or hyperflexed lateral positions. In such instances, as well as for upper or deep abdominal, thoracic vascular, most neurosurgical and virtually all head and neck surgical procedures, general endotracheal anesthesia is indicated.

Do you have any additional comments on the type of anesthesia to choose for cardiac patients?

Since narcotic or narcotic tranquilizer mixtures *do not* reduce cardiac output when given with judicious restraint but *do* reduce metabolic demand and cardiac work, these agents, at least at present, appear to offer the safest base on which to build a general anesthetic. Additional anesthesia can be provided by giving varying concentrations of inhaled nitrous oxide up to a 70 percent mixture. Muscle relaxation required to produce a smooth surgical procedure can be obtained by the use of intermittent or continuous succinylcholine infusion or by giving tubocurarine. These muscle relaxants do not have any cardiac effect.

Are any additional procedures needed to insure a smooth operative course for cardiac patients?

At the termination of the operation, the respiratory depressant effects of the narcotic may be reversed by using an intravenous narcotic antagonist leading to early awakening and adequate respiratory exchange. Finally, let me add that every effort should be made to avoid the use of halothane, ether, methoxyflurane and cyclopropane because of their cardiodepressant and arrhythmic effects. Fortunately patients with serious heart disease usually require less of the anesthetic agent to provide operating conditions.

What ancillary medical problems may complicate the anesthetic management of the cardiac patient?

Uncontrolled diabetic acidosis in a patient with an acute surgical abdomen is not an uncommon problem. Prompt intravenous treatment of the acidosis and correction of the associated serum electrolyte abnormality are of paramount importance.

William G. Leaman, Jr., M.D., edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.

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Fertility and Sterility, January 1
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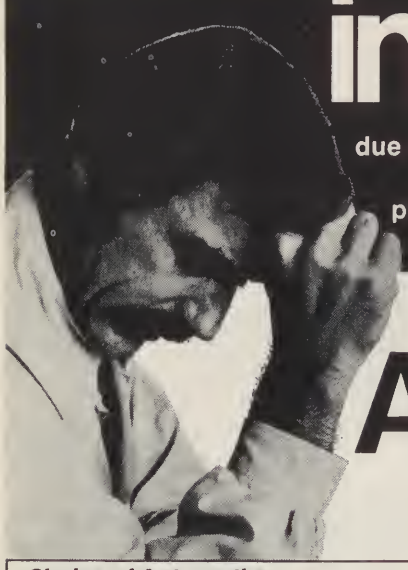

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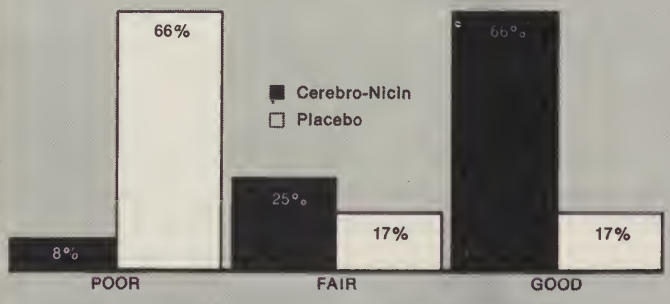

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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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Rehabilitation of the Stoma Patient

Most promising and encouraging has been the emergence of the enterostomal therapist as a new paramedical aide. Started about ten years ago as an experimental project, there are now sixty-five men and women certified in this specialty. They are trained at one of three centers: Cleveland Clinic, Cleveland, Ohio; Ferguson Clinic, Grand Rapids, Mich.; and Harrisburg Hospital, Harrisburg. Trainees are mainly nurses with a special interest in these patients. After their training is completed they can function in many ways. As resource people for the Medical and O-R Staffs they can call attention to modern and new equipment and appliances. As part of the continuing education program they help hospital personnel keep abreast of new developments. They can be helpful to the social worker in planning the patient's transition from hospital to home and work situation. Finally the patient has access to one highly skilled in the problems that are strange, embarrassing and frightening.

Not every hospital has sufficient need to employ its own full time enterostomal therapist. It has been estimated that an institution should have eight to ten stoma patients per week to make it feasible. Hospitals with lesser case loads can serve their stoma patients by arranging with a therapist to consult regularly in setting up a stoma program. Thus by being mobile, an enterostomal therapist can have a regional impact on stoma care.

The recent Conference on Cancer of the Colon and Rectum called attention again to the problems facing stoma patients. It is estimated that 86,000 stomas are created annually in the United States. All of them need training in self-care in addition to help with other problems due to their disease and social situations. Until recently the type of help available left much to be desired. The development of ostomy self-help groups about twenty years ago were a reflection of this need, and at present there are more than a hundred such groups in active existence.

Every hospital can establish a Stoma Rehabilitation Clinic. Here, in the first post-operative year, the patient can be taught self-care, the proper management of the stoma and the associated appliances. They can be taught proper care of the skin and the avoidance of skin problems as well as the control of odor and gas. In addition they would be taught basic diet control and given emotional support.

Later the clinic classes would provide additional information, further reassurance would be given as needed and the patients would be brought up to date on new equipment. Such clinics would always be available for crisis problems such as fistula, hemorrhage, prolapse and others.

As we put more emphasis on the *quality* of survival of the cancer patients such paramedical help as the enterostomal therapist becomes an essential element in any rehabilitation program.

"NURSING MANAGEMENT OF THE PATIENT WITH CANCER", a half-hour film in color, has been released by the American Cancer Society, as a valuable education tool for nurses. The film demonstrates nursing procedures used with patients who have experienced laryngectomy, tracheotomy, colostomy or cystectomy. In this scene from the film, the nurse is irrigating the patient's colostomy. Later the patients learn to do this themselves.

CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.

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Wisdom in the wilderness

The crusading efforts of the Pennsylvania Insurance Department to effect changes in the health care field has caused considerable public concern in the Commonwealth. The call for change is based on a compilation of criticisms leveled at physicians and hospitals for a number of years.

The news media have dramatized such criticism and have created a public image of those involved in medical care as showing a total lack of concern for the patient or his pocketbook.

In a recent bulletin of the Insurance Department there appeared an article entitled, "From The Desk Of Commissioner Dennenberg." It said in part:

"The Pennsylvania Insurance Department in the last four months has run head long into a line of unreasonable people. We've encountered hospitals, doctors, insurance companies, Blue Cross plans, auto manufacturers, and all too often these groups seem to be unreasonable, at least to us.

"This led me to ask one of my staff whether perhaps there was something wrong with us rather than those sitting across from us at the conference table. One of my assistants replied - 'Yes, there is something wrong with us— *We want change.*'

"Change does not come easily and this is true of hospital care as well as the other areas of concern of the Insurance Department. The special interest groups still manage to thwart needed change, obviously needed change and urgently needed change.

"The automobile manufacturers still indulge in what Ralph Nader called criminal fraud in selling the public unreasonably delicate and unsafe automobiles. Despite all the publicity, all the pressure, all the pleas, and all the press, the 1971 models are even more delicate than the 1970 models. More durable automobiles would cut the sales of the auto manufacturers, so perhaps it is too much to expect them to act against their economic interest.

"The trial lawyers are intent upon clinging to a legal system for auto accidents that produces delay, waste, inefficiency, fraud, inequity and disaster for virtually every group in our society— except the trial lawyers. Change will not come under the sponsorship of the trial lawyers, but in spite of them. No-fault hits the bar in the breadbasket, so perhaps it is too much to ask that the bar would voluntarily make changes that could adversely affect their billion dollar auto injury business. Twenty-five percent of the auto bodily injury premium dollar goes their way, for claims adjustment expenses or legal fees, and they are likely to resist any arrangement that will cut that share.

"The hospitals and the doctors also seem firmly lined up against change. The only solution of many of the hospitals seems to be more money, not more efficiency; more expenditures, not better quality patient care; bigger budgets, not more care for more people. Hospitals are not eagerly embracing schemes to cut their budgets or restrict or even monitor their operations.

"Nor are the doctors likely to voluntarily bring about needed change. They now are in the best of all possible worlds. Demand exceeds supply and the doctors can call their own shots. The American Medical Association is the classic example of a special interest group whose vast political influence permits it to work against the public interest and against needed change. The medical monopoly is a cruel task master and an expensive one.

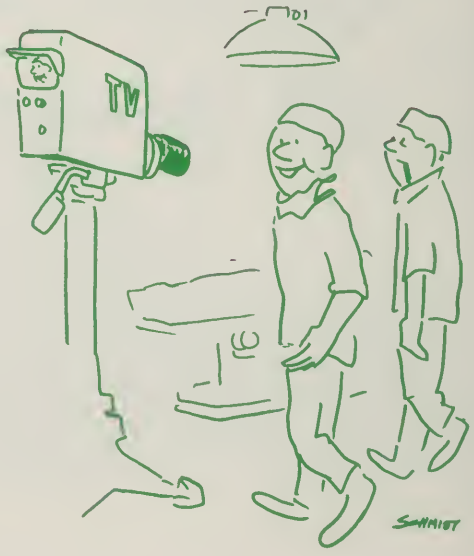
"Change will not come to pass without a battle, but it is a battle the public must fight. Consumerism is most urgently needed in the hospitals and in the offices of doctors as well as in other places which have a direct and profound impact on the business of insurance.

"We intend to make change in the public interest while protecting the legitimate interests of all persons involved. We ask for your help and your ideas in this endeavor."

After having read this article, I recalled the words of Marcel Proust in his *Remembrance of Things Past*: "We are not provided with wisdom, we must discover it for ourselves, after a journey through the wilderness which no one else can take for us, an effort which no one can spare us, for our wisdom is the point of view from which we come at last to regard the world."

If the Insurance Department, with its myriad problems, is still wandering in the wilderness, let us hope it comes at last, and soon, to that wisdom Proust promises.

DAS



COME ON HARRY... THIS ISN'T BEING BROADCAST... ONLY RECORDED.

Anthony E. Maas, M.D.
Associate Pathologist
Harrisburg Polyclinic Hospital
Harrisburg

Your communication in the August issue of the PENNSYLVANIA MEDICINE concerning autopsy is a thoughtful discussion of both sides of an issue which has been receiving much pressure from highway safety planners and such bodies as the National Motor Vehicle Safety Advisory Council to Secretary Volpe.

I believe your point of view would be a helpful one in non-certional evaluation by the American Association for Automotive Medicine. Your participation with this group would certainly be valuable. The Annual Meeting this year will be at the Broadmoor Hotel in Colorado Springs Wednesday through Friday, October 20 through 22, 1971. I am aware that the program has already been finalized, but it might be well for you to consider a participation in the 1972 program. In the references which you cite to Paul Gikas and Dr. Huelke, I would also like to point out that Don has just completed his term as President of the American Association for Automotive Medicine. The 11th Annual Meeting was held here in Philadelphia a few years ago during the time of my own presidency and the proceedings have been published by Charles C. Thomas in Springfield, Illinois.

In addition to the references which you cite, a very extensive group of thorough investigations of fatal highway collisions between 1962 and 1963 was organized under the direction of Alfred L. Moseley and the studies were subsequently published by Harvard Medical School 1963.

The current secretary of the American Association for Automotive Medicine is James L. Weygandt, M.D., 716 Monroe Street, Sheboygan Falls, Wisconsin 53085, and I am writing him by copy of this letter to forward membership materials to you.

Thank you for taking time to make your thoughtful contribution to PENNSYLVANIA MEDICINE.

Arthur H. Keeney, M.D., D.Sc.
Ophthalmologist-in-Chief
Wills Eye Hospital
Philadelphia

To the Editor:

The new morality, plus pornography, plus the contraceptive pill, have led to an era of extreme sexual laxity. That this sexual laxity has led to a tragic re-explosion of venereal disease is due in great part to the false assumption by large numbers of ignorant youth that the pill makes the world safe for unrestricted sex.

This misconception should be counteracted by a warning, as follows:

"This product (or medication) is intended for the prevention of pregnancy only, and will not protect persons of either sex from gonorrhoea, syphilis, chancroid or any other venereal disease."

The warning, printed in good size, legible type, should be required, preferably by federal law, to be attached to each container of contraceptive drugs, whether dispensed in the original package or as a separate prescription, and to the container of each intra-uterine contraceptive device.

This would serve at least as valuable a purpose as the warning on cigarette packages.

DAVID M. DAVIS, M.D.
Professor Emeritus of Urology
Jefferson Medical College
Philadelphia

Mrs. Helene Wohlgemuth
Secretary of Public Welfare
Department of Public Welfare
Harrisburg, Pennsylvania

Dear Mrs. Wohlgemuth:

The glaring fallacy in your directive regarding the review of Medicaid cases is, that one cannot conceivably think a day or two after a patient's hospital admission the same thoughts of the attending physician at the time of admission. Medical indications for admission cannot always be spelled out in writing. There is still, and always will be, the art of medicine and intuition. This is not an exact science.

Your requirement of review places me in an uncomfortable position of lack of confidence in my colleagues, and as an internist, I do not wish to be a member of your N.K.V.D.

R.F. Waldo, M.D.
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February 21, 22, 23, 1972

Electrocardiography: Model for Normal and Intraventricular Conduction Defects — Heart Block & Hemiblock: Indications for Pacing— Peter C. Block, M.D., Cardiac Unit, Massachusetts General Hospital

Diagnosis, Treatment, Prevention of Specific Viral Diseases in Man — Thomas C. Merigan, M.D., Chief Div. Infectious Diseases, Stanford University Medical Center

Cancer Immunology Applied to Early Diagnosis of Tumor Growth, Detection CEA in Patient's Blood— Phil Gold, M.D., Ph.D., F.R.C.P. (C). Montreal Gen. Hospital Div. Clinical Immunology & Allergy

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Dr. _____

Address _____

obituaries

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Wesley L. Allison**, Allison Park; University of Pittsburgh School of Medicine, 1909; age 86; died June 27, 1971. His sister survives him.

○ **George P. Ard**, Hanover; University of Pennsylvania School of Medicine, 1907; age 88; died June 29, 1971. He is survived by a sister and a daughter.

○ **Jose G. Blanco**, Charleroi; University of Maryland, 1941; age 54; died March 1, 1971. Information is not available on survivors.

○ **Arthur L. Bolden**, Philadelphia; Temple University School of Medicine, 1927; age 67; died June 29, 1971. He is survived by two sons, two sisters, and a brother.

○ **David Budin**, Philadelphia; Medico-Chirurgical College of Philadelphia, 1914; age 82; died July 5, 1971. His survivors include his wife, two sons, a daughter, and a sister.

○ **Stanley B. Butrym**, McKeesport; Georgetown University School of Medicine, 1924; age 75; died July 10, 1971. He is survived by his wife and three sons.

○ **Thomas W. Cook**, Pittsburgh; Jefferson Medical College, 1920; age 75; died June 18, 1971. In addition to his wife, he is survived by two sons, one of whom is T. William Cook, M.D.

○ **Joseph A. Daly**, Philadelphia; Temple University.School of Medicine, 1920; age 76; died July 2, 1971. His survivors include his wife, two daughters, two sons, and a sister.

○ **Charles S. Duttenhofer**, Churchtown; Jefferson Medical College, 1920; age 76; died July 14, 1971. He was chief of the outpatient department at Lancaster General Hospital. He is survived by a son, a daughter, and a sister.

○ **Robert C. Hopkins**, East Girard; University of Maryland School of Medicine, 1951; age 48; died June 24, 1971. He is survived by his wife, two daughters, a son, and a sister, Mary Evelyn Hopkins, M.D., Honolulu.

○ **Nile P. Keller**, Ft. Lauderdale, Fla.; University of Pittsburgh School of Medicine, 1907; age 87; died July 13, 1971. In addition to his wife, he is survived by a daughter.

○ **Edmond M. Knesevitch**, Lehighton; St. Joseph's University, Beirut, Lebanon, 1951; age 45; died July 15, 1971. He is survived by his wife, a daughter, three sons, a sister, and two brothers.

○ **Mark R. Leadbetter**, Pittsburgh; Hahnemann Medical College and Hospital, 1943; age 53; died July 18, 1971. He was a fellow of the Industrial Medical Association and was a physician for Merck & Co., Inc. in Danville. He is survived by his wife, a daughter, and two sons.

○ **John O. MacLean**, Scranton; Dalhousie Medical College, Halifax, Nova Scotia, 1922; age 75; died June 21, 1971. Dr. MacLean was president of the Moses Taylor medical staff for over sixteen years. He was a fellow of the American College of Surgeons. He is survived by his wife, three sisters, and a brother, Angus L. MacLean, M.D., Baltimore, Md.

○ **Benjamin F. Miller**, Philadelphia; Harvard Medical School, Boston, Mass., 1933; age 63; died June 28, 1971. He was associate professor of surgical research at the University of Pennsylvania and a National Research Council fellow at Rockefeller Institute in New York City. He is survived by his wife; a son; two daughters, one of whom is Susan Schneider, M.D.; a stepdaughter; a brother; and a sister.

○ **Harold E. Musser**, Somerset; University of Pittsburgh School of Medicine, 1931; age 65; died June 20, 1971. Dr. Musser was chief of surgery and a former chief of staff at the Somerset Community Hospital. He is survived by his wife, and two sons, one of whom is Harold E. Musser, Jr., M.D., Somerset.

○ **Mearl D. Rhoads**, Johnstown; Eclectic Medical College, Cincinnati, Ohio, 1925; age 72; died July 14, 1971. He is survived by his wife and a son, John Rhoads, M.D., Manassas, Va.

○ **David N. Yatzkan**, Homestead; Chicago Medical School, 1948; age 46; died July 14, 1971. He was a member of the American Academy of Opththalmology and Otolaryngology. He is survived by his wife, three children, his parents, a brother, and a sister.

○ **Walter T. Annon, Sr.**, San Mateo, California; Jefferson Medical College, 1918; age 78; died July 21, 1971. He served for more than 50 years on the staffs of Jefferson Memorial and Methodist Hospitals in Philadelphia. He is survived by his wife, a daughter, a[l] two sons, one of whom is Walter Annon, Jr., M.D., Philadelphia.

○ **Constantine P. Faller**, Harrisbu Medico-Chirurgical College of Phi delphia, 1916; age 80; died August 1971. Dr. Faller was a fellow of American College of Physicians, College of Physicians of Philadelph the International Academy of Me cine, the American Geriatric Socie and the International Society of Int nists. There is no information regardi survivors.

○ **Lloyd S. Hutchison**, Lancast Jefferson Medical College, 1930; a 67; died August 10, 1971. He was ch of the Department of Otolaryngology Lancaster General Hospital until l retirement. He was a diplomate of t American Board of Otolaryngolo and a former vice-president of t Pennsylvania Academy of Opththalm logy and Otolaryngology. He is su vived by his wife, three daughters, anc son.

○ **George S. Klump**, Williamspo University of Pennsylvania School Medicine, 1926; age 69; died August 1971. He was active in the Penns vania Medical Society, serving as tru tee and councilor for ten years, a then as chairman of the Board of Tru tees and Councilors in 1952. He was the Judicial Council for nine years. H was a delegate to the American Medic Association for thirteen years and member of the advisory board of t Pennsylvania Department of Healt He won the Public Health Associatic award of merit in 1950. The Universit of Pennsylvania Medical Scho honored him by naming the cardi vascular laboratory for him. He is su vived by a daughter and a sister.

○ **Max Littner**, Bethlehem; McGi University Faculty of Medicine, 192 age 69; died August 12, 1971. He was member of the American Psychiatri Association, the American Academy General Practice, and the America Heart Association. He is survived b his wife, one daughter, one son, fiv brothers, and a sister.

○ **Thomas F. O'Leary**, Altoona; Je ferson Medical College. 1931; age 6 died July 29, 1971. He is survived by daughter, a brother, and five sisters.

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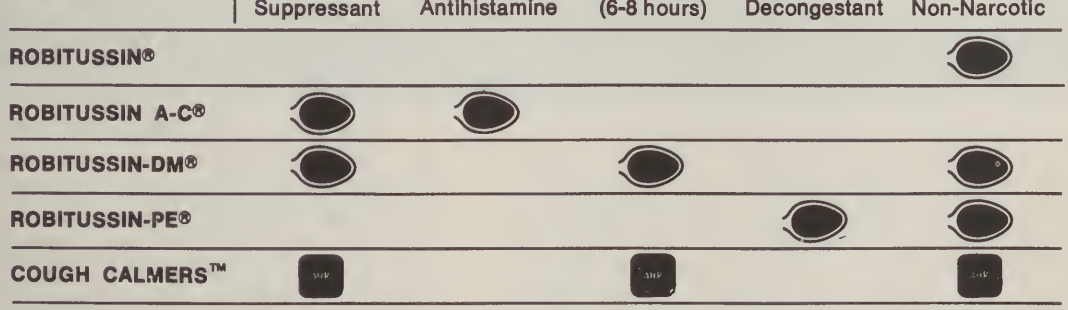

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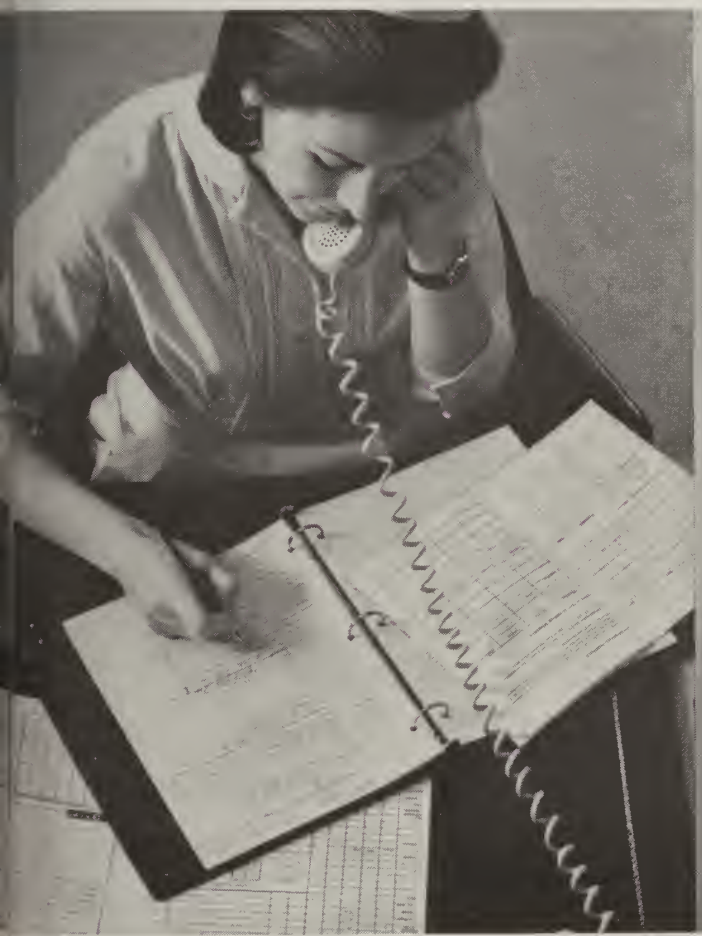

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Sinequan (doxepin HCl) **Capsules**
Contraindications. Sinequan (doxepin HCl) is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan (doxepin HCl) is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan (doxepin HCl) has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan (doxepin HCl) in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan (doxepin HCl). The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan (doxepin HCl) has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan (doxepin HCl), however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan (doxepin HCl) can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan (doxepin HCl) does exert a significant blocking effect. In addition, Sinequan (doxepin HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Sinequan (doxepin HCl) is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., and 50 mg. of doxepin in bottles of 100; and 25 mg. and 50 mg. in bottles of 1000.

More detailed professional information available on request.

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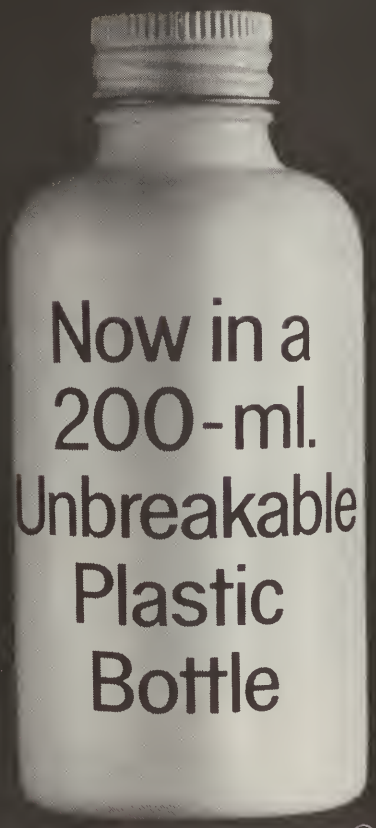

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Fingertip Injuries

THOMAS G. FRAZIER, M.D.
Philadelphia
WILLIAM P. GRAHAM, III, M.D.
Hershey

PARTIAL AMPUTATIONS are commonplace injuries in the home and industry. Although they may appear minor in nature, the initial treatment of these defects plays an important role in maintaining a functioning hand with a minimum of morbidity.

From July 1967 to January 1970, eighty-seven patients with avulsions of varying amounts of distal digital tissue were treated at the Graduate Hospital and the Hospital of the University of Pennsylvania (Table I). The methods of treatment used, their results, and the reasons for the election of the particular method of treatment are to be discussed (Results: Tables II and III).

Eight patients who had free grafts applied to the injured area had a slough of these grafts. Six required regrafting or another secondary procedure for wound closure. Two patients who had Kutler [1] advancement flaps done developed complications, the most severe of which was tenosynovitis in a man who had sustained his amputation with a butcher knife. Ultimately healing was obtained after incision and drainage of the infected tendon sheath plus revision of the amputation site with futher digital shortening.

Three patients who had no initial treatment beyond that of local wound care had later revisions of their injured area because of excessive sensitivity or unsatisfactory cosmetic results. Revisions of the pedicle flaps from the chest or abdomen were done in two patients and one patient who had a revision of an unsightly sensitive finger tip following primary closure of the initial wound.

Figure 1. Repair of nondominant thumb in an 85 year old seamstress after injuring thumb in a car door. Injured thumb and amputated part.

Discussion

Complications in these patients (Table II) were the result of the degree of trauma to the injured member rather than the fault of the procedure utilized with the exception of the patient who severed the tip of his finger with a butcher knife who probably would have been better treated with a less extensive procedure intially. More complications occurred in those pa-

Dr. Graham is an associate professor of surgery at the Milton S. Hershey Medical Center of the Pennsylvania State University. Dr. Frazier is an assistant instructor of surgery at the Hospital of the University of Pennsylvania.

TABLE I

Reconstruction of Amputated Finger Tips

Split thickness skin graft	46
Full thickness skin graft	9
Kutler V-Y advancement flaps	12
Pedicle flaps	3
Revision and primary closure	11
No closure	6
	87

tients treated with free skin grafts which reflects the choice of this procedure for some of the more severely injured finger tips and as an interim treatment. It is impossible to assess the time lost from work as many of these patients were indigent and unemployed. It was frequently possible to return individuals to work even prior to complete wound healing when procedures other than pedicle flaps were used.

The method of repair utilized in reconstructing a soft tissue avulsion of the finger tip depends upon 1) the finger injured, 2) the amount and type of tissue lost, 3) the age of the patient, 4) the patient's occupation and avocation as well as 5) the configuration of the loss. Five alternatives can be considered in treating these injuries. 1) Primary wound closure with or without digital shortening, 2) Free grafts (the replacement of the detached tissue, partial or full thickness free skin grafts) 3) Local or regional pedicle flaps, 4) pedicle flaps from a distance, 5) local wound care without closure.

Figure 2. V-Y flaps designed.

Local primary wound closure does not require extensive immobilization or awkward posturing thus rendering it quite favorable for elderly patients. It is effective for small losses of skin and can be used for the ring and little fingers in which length and sensation are usually not as critical as the other fingers. At times a painful scar may result which will require revision and too tight a closure under tension may result in wound breakdown.

The technique of closure by the advancement of lateral "V" shaped flaps facilitates the maintenance of length without impairing sensory function

Figure 3. Flaps advanced over end of finger on subcutaneous pedicles.

TABLE II

Complications Following Treatment Traumatic Amputations

Split thickness skin grafts (46)	
Slough	7
Lost to follow up	13
Full thickness skin graft (9)	
Slough	1
Partial Slough	1
Donor site infection	1
Joint Stiffness	1
Lost to follow up	1
Kutler V-Y Flaps (12)	
Slough of flap*	2
Tenosynovitis*	1
Joint Stiffness	1
Neuroma	1
Revision and Closure (11)	
Slough	1
Joint Stiffness	1
Neuroma	1
Lost to follow up	2
No Closure (6)	
Infections	2

* A Slough of flap and tenosynovitis both occurred in the same patient.

TABLE III

Frequency of Secondary Revisions following traumatic injuries of the finger tip

plit thickness skin graft	5
o closure	3
utler V-Y advancement flaps	2
edicle flaps	2
ull thickness skin graft	1
evision and closure	1
	14

d provides a smooth rounded tip ich is seldom painful or tender.[1] ie procedure is easy to perform and s the advantage of providing intact nsation in the amputated area (Illus- ations 1, 2, 3, 4 and 5).

Free skin grafts are the most versa- e method of closure for most avul- n injuries.[3] The procedure is simple d can be performed with a minimum instruments with an excellent ance of success. A less than op- num wound can be treated with a lit thickness skin graft and if no mplication develops, a flap or other ocedure may then be done earlier, th a reasonable assurance that it will cceed without infection. The prefer- le donor site for free grafts is either e medial aspect of the upper arm or e hypothenar eminence. The clas- al use of the antecubital space is oided because of the chance of a conspicuous and occasionally sensitive scar. The groin crease may be used to obtain sufficient skin to cover a large area.

Generally full thickness skin grafts are thought to provide a more desirable surface but the increased shrinkage of the partial thickness skin graft can be used to advantage by reducing the amount of abnormal skin in the finger tip. Tactile gnosis rarely returns to these split grafts.

A flap may be necessary when a significant pad of subcutaneous tissue has been lost on one of the major digits particularly if bone or tendon has been exposed. Local cross finger flaps require immobilization of more than one finger and necessitate a skin graft to the donor area with a chance for an undesirable scar, especially in women. More than one procedure is necessary, delaying the return of the individual to his occupation. The palmar or thenar flap has fallen into disrepute and is used much less frequently than previously due to problems with digital stiffening and an occasional uncomfortable scar on the palm particularly in the working man.

Primary neurovascular island transfers are interesting surgical challenges but are probably not warranted as an initial procedure in the traumatized digit except in unusual circumstances.

Allowing the wound to remain open is often a reasonable procedure, especially in children and with minor tissue losses in adults. The replantation of avulsed tissue can be tried with caution in children in whom it is more often successful than in adults.

If available, allografts can be used as temporary biological dressings to promote healing and reduce the chance for infection.[4]

If multiple digital injuries have resulted, parts may be borrowed from irrevocably damaged fingers to restore the less severely traumatized ones.[5] When the damage to the hand or the digits is extensive, primary therapy may be deferred temporarily until areas of demarcation have become established and a clearer view gained of the extent of the damage.[6]

igures 4 and 5. Postoperative appearance one year after injury.

Summary

Although the treatment of composite tissue loss from finger tips must be individualized for each situation, generally free grafts offer the best opportunity to insure early healing in the simplest and most expeditious manner. Local advancement flaps, when suitable, provide a durable, nearly normally innervated cosmetically acceptable finger tip.

Pedicle flaps from a distance are necessary when too much tissue has been lost to allow satisfactory coverage by any other method.

Regional flaps, although useful at times, can result in joint stiffness, conspicuous local scars and painful donor sites.

The contaminated wound or one seen late after an injury is best treated by local cleansing and delayed primary closure. To permit secondary healing to proceed yields unpredictable but at times satisfactory results. □

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Management of Fingertip Injuries

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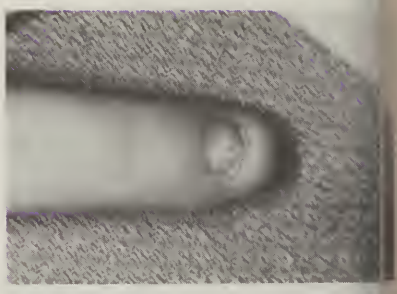
THERE ARE SEVERAL million injuries to the hand which occur in industry and at home yearly, and the tips of the fingers are involved in most of the reportable injuries. The majority are simple lacerations or mild crush injuries which respond often to virtually no treatment, and heal without deformity, with minimal time lost from work.

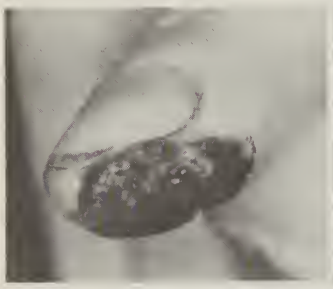
One could title this discussion "Care of Minor Hand Injuries." However, this leads to the misconception of the minor nature of fingertip injuries. Although Adrian Flatt (1959) entitled his text, "The Care of Minor Hand Injuries," we really must consider any injury which cripples a productive wage earner or family head as a major and

Case 1 (A.) Two year old with partial amputation in a car door injury.

(B.) Repair.



(C.) Complete return of function with 4 months of injury.

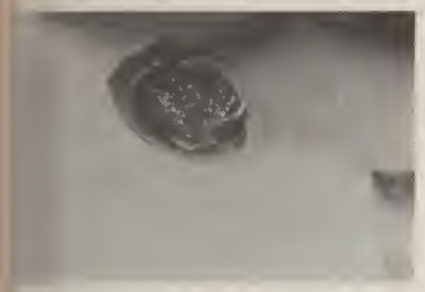


Case 2 (A.) Tip loss in 36 year old female butcher.

(B.) Donor area used on adjacent middle finger.

(C.) Fixation with peripheral tie over sutures.

(D.) Final result 5 months la



Case 3 (A.) Tissue injury in 26 year old hospital aid.

(B.) Removal of subcutaneous fat from fingertip tissue for full-thickness graft.

(C.) Final result 4 months.

ostly injury.

This discussion includes those fingertip injuries involved in loss of soft issue leaving insufficient skin for primary wound closure. Under these ircumstances the treatment for a simiar injury may fall into several choices. The choice will depend on individual ircumstances involved. The initial valuation must include adequate hysical examination and medical hisory to determine the status of the and and finger bones, tendons, joints, erves and skin deficits. Adequate hisory of the injury to determine the legree of crush, type contamination, ength of time since injury, type of ork the patient does, and general verall condition must be obtained. The age, sex, handedness, education nd motivation of the patient must all e considered in the final decision on anagement of each individual finger njury because this data often is ecisive on the best repair for the indiidual. The following types of repair nust be considered:

1. Finger shortening and primary kin closure.
2. Free split, or full-thickness augenous grafts.
3. Local pedicle flaps.
4. Distant pedicle flaps including:
   (a) Island
   (b) Cross-finger
   (c) Palmar
   (d) Abdominal
   (e) Cross-arm

Each category will be separately considered and representative case materil from several categories provided to lemonstrate variable treatment plans.

Viable tissue should always be preserved when dealing with these fingertip injuries. To determine viability of tissue is not always easy. Case #1 lemonstrates the fingertip of a two year old child referred to us after the physician initially examining the injury had recommended amputation of the partially severed fingertip. Simple suture and proper immobilization led to a completely normal functional result as demonstrated in the photographs. This type of history and recommended mismanagement is what basically led us to formally present some review cases on appropriate management of fingertip injuries.

(1) Finger Shortening and Primary Skin Closure

This is sometimes requested by the working man since it is the quickest way to restore him to work. When this involves the index finger or thumb, amputation is a very large price to pay with subsequent large loss of functional pinch due to the shortening of these very important fingers, and other alternatives must be discussed with the patient. Occasionally, shortening is recommended when this will allow closure by remaining soft tissue without additional sacrifice of flexor or extensor tendons. For example, it would be unwise to leave the bulbous end of the distal middle phalanx when shortening will allow tip primary closure as the simplest technique. In this situation, both the flexor and extensor distal insertions have been sacrificed from the missing distal phalanx and shortening of the finger leads to relatively little functional movement of the remaining now most distal proximal interphalangeal joint. However, shortening of only a few millimeters of the distal phalanx may result in loss of nail bed or flexor and extensor tendon insertion and is too big a sacrifice to achieve closure. A distal finger stump without nail in a woman would be cosmetically unacceptable. A shortened distal phalanx stump, if nail bed is spared and allowed to grow out over the shortened tip, will often result in a fingertip resembling a cat's claw and also would be less than ideal in function or cosmesis in any age or sex. To generalize then, when the injury involves only the distal tissue overlying the distal phalanx we feel it is best to spare all possible viable tissue and we seldom can find justification for shortening and primary fingertip closure.

(2) Free Split or Full-Thickness Grafts

Free skin grafts have a definite place in tip injuries if there has been loss of skin only. Grafts take well and hold up long term under trauma, however, only if there is adequate protection of the bone and tendon by subcutaneous coverage. Donor sites are readily available with little morbidity if they heal without complication. The lateral side of the involved finger may easily be used for a split graft without requiring further anesthesia than digital block. This is demonstrated in Case #2 where a #11 Bard Parker blade is used to shave adequate split-thickness skin from the lateral side of a finger to cover a fingertip injury involving full-thickness skin loss in a thirty-six year old female supermarket butcher with adequate soft tissue protection of the distal bone. Other split-thickness graft donor areas are the forearm, leg or hypothenar eminence on the ulnar side of the palm. Full-thickness grafts can be obtained from the wrist, medial aspect of the arm or inguinal area as the most commonly used sites. This coverage is demonstrated in Case #3 with skin loss on a hospital nurse's aid, age twenty-six. In comparing a split graft versus a full-thickness graft, one must consider that the split graft will have a better chance for take than a full-thickness graft but

Case 4 (A.) Tip amputation in 48 year old construction engineer.

(B.) Palmar flap prior to detachment 3 weeks later.

(C.) Final result 6 months later showing incomplete finger extension, all healed.

often is more sensitive to touch after final healing has been accomplished. Return of touch sensation is approximately equal for both by comparison. The amputated part can often be used as a site of donor full-thickness autograft if conditions of crush and contamination are not too severe. Fingertip skin replaced as full-thickness graft after defatting provides excellent results and retains ideal characteristics perhaps better than grafts taken from other sources of the body. Free grafts, however, cannot be used and will not take unless paratenon or periosteum are present overlying the vital structures. To generalize, however, even though these protective structures are present, free grafts should probably not be considered except on extensor surfaces where functional requirements are not as strict.

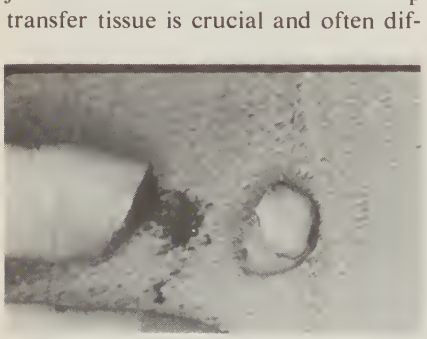
(3) Local Pedicle Flaps

Local pedicle flaps such as visor, rotational or spiral flaps utilize the principle of sacrifice of dorsal, nonpressure area skin transferred to more vital volar specialized skin. There is limitation on the amount of tissue available when crush or contamination compounds the injury. The judgment of prediction of ultimate survival of adjacent skin as a source of local flap transfer tissue is crucial and often difficult. In all cases, primary wound healing in the most rapid manner without complication is essential and is the sine-qua-non in successful management of any hand injury. In the oblique fingertip injuries where more volar than dorsal skin is amputated, the bipedicle lateral based visor flap from the dorsum to the volar side is particularly useful to provide good pad, sensation and function. When adjacent tissue has been crushed, it is perhaps better to utilize other tissue sources rather than witness gradual thrombosis of this crushed tissue which was interpreted incorrectly for ultimate survival. Local flaps should be considered next in order of simplicity after free grafts, however, and secondary staging is eliminated with earlier return to function when compared with distant pedicle flaps.

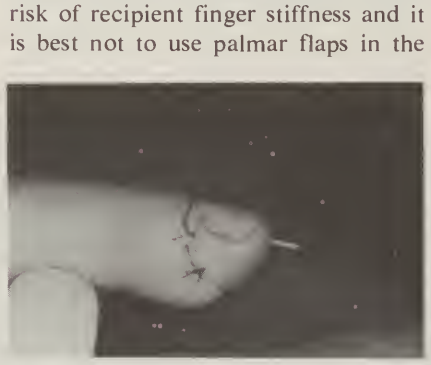
(4) Distant Pedicle Flaps

Distant pedicle flaps should be considered only when the above simpler procedures have been ruled out as not feasible. In the female or young, perhaps the palmar flap can best be used to avoid creating cosmetic deformity on dorsal adjacent donor areas such as those obtained from cross-finger flaps. These, however, run the risk of recipient finger stiffness and it is best not to use palmar flaps in the patient over fifty except the fem where cosmetic importance assume a more dominant role. There is limitation in size of flap available from e palm and these should be reserved oy for small defects of the finger). Case #4 demonstrates the typul result one can achieve to the finger following a palmar flap in a forty-ei t year old construction engineer.

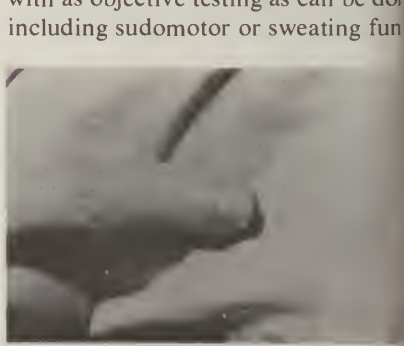
The cross-finger flap genera provides more variable source f donor skin with excellent blc supply. Dissection of these should carried out in the level beneath dorsal veins and on top of the areo layer covering the extensor tendons an adjacent finger. This should done with a bloodless field obtain with the tourniquet to obtain t proper tissue plane. The tourniquet released after dissection to check fl viability and to obtain hemosta prior to application of split-thickn skin grafts to the donor finger ar Sturman and Duran (1963) present an excellent review of late results f lowing fingertip injury repairs. Th evaluated sensory function by lig touch, two point discriminatic stereognosis and pinprick. They al evaluated work time loss, joint stiffn with as objective testing as can be do including sudomotor or sweating fun



Case 5 (A.) Tip injury in a 48 year old widow factory worker.



(B.) Immediate suture with K-wire fixation.



(C.) Final result four months later. Some residual tenderness and secondary curettage of bone sequestrum was necessary.

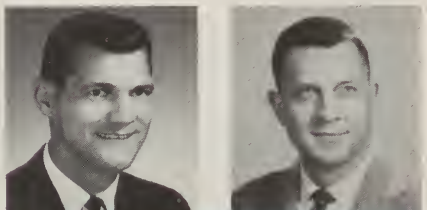
ion by Moberg Ninhydrin-Copper Sulphate technique (1958). Summary of their review of two hundred and thirty-five patients led to their conclusion that crossfinger flap satisfied most overall criteria best. There were less subjective complaints and although the lost time from work was greater, the overall best long term results were obtained with cross-finger flaps.

Island pedicle flaps rarely need be used in primary repair and can be used secondarily if sensation is mandatory on such areas as the thumb or index fingers. The complexity of abdominal or cross-arm flaps eliminates them in all but the large tissue defects and will not be considered in the cases presented herein. In general, several reviews have appeared on management of hand injuries similar to the tissue defects presented in cases presented herein. Brown (1938) and Koch (1953) should be mentioned here for their work in the care of the acute hand injury. Barclay (1955) also presented late results of tip injuries and his conclusions were similar to those mentioned above by Sturman and Duran. Douglas (1959) has reported successful replacement of completely avulsed portions of fingers as composite grafts, but in my hands these have led to prolonged wound healing periods with partial take and painful residual scarring.

Case 6
(A. and B.) Amputation injury in 18 year old machinist. (C.) Cross-finger flap repair prior to detachment at 14 days. (D.) Final result 6 months after injury.

Case #5 demonstrates re-implantation of the distal fingertip in a forty-five year old widow factory worker. The convalescent period was prolonged and the patient subsequently was admitted for curettage of small draining sinus in the form of a bony sequestrum beneath the nail bed which was part of the composite graft re-implanted. The cosmetic result was good but morbidity prolonged. McCash (1958) reported successful toe pulp free grafts as another possible source of similar type donor skin and this is mentioned only for thoroughness. Kislov and Kelly (1960) provided notes on the use of K-wire fixation and cross-finger flaps and should be referred to as a simple useful adjuvant in postoperative immobilization. Other papers by Curtis (1957), Woolf and Broadbent (1967), Tempest (1952) and Hoskind (1960) provide support for use of cross-finger flaps because of versatility and long term functional success. The details of technique can be found in several of these papers.

Case #6 demonstrates the result obtained in cross-finger flap technique in an eighteen year old machinist apprentice. Detachment was carried out at fourteen days with satisfactory healing, sensation, and without loss of range of motion of either donor or recipient finger. Detachment of cross-finger flaps can often be carried out at an early stage at ten to twelve days following inset if the recipient bed was originally healthy and satisfactory healing has progressed during the follow-up close observation. Donor finger morbidity is low; however, the cosmetic deformity is somewhat detrimental when the injury has occurred in the patient who may focus on this.



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Summary

Discussion has been presented of the management of so-called minor fingertip injuries and the relative merits of various types of wound coverage including finger shortening and closure, split and full-thickness grafting and several methods of adjacent and at-a-distance flap coverage. Six cases are presented briefly with illustrations to document several methods of repair including primary suture, split-thickness skin graft, full-thickness skin graft, palmar flap, tip re-implantation as composite graft, and cross-finger flap. The relative merits of cross-finger flaps are emphasized. □

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Massive Pulmonary Embolism

Successful Surgical Treatment of Two Cases

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ACUTE, MASSIVE pulmonary embolism remains a major clinical problem despite numerous recent advances in early diagnosis and treatment.[4,7,8,11,14] The abundance of recent literature discussing the many therapeutic possibilities attest to the difficulty in selection of patients for operative management. Many recent articles have reviewed the history of pulmonary embolism and the evolution of the surgical treatment[4] from Trendelenberg's pioneering attempts[13] to the first successful case using cardiopulmonary bypass by Sharp in 1967.[12] Interestingly, this first use of heart-lung bypass in the treatment of pulmonary embolism did not occur until twenty-eight years after the experimental development of temporary cardio-respiratory support with survival in animals by Gibbon in 19[illegible]5 Since relatively few patients are carefully cut candidates for surgical management, the success of these cases is tempered by the judgment of the clinician into whose hands they fall.[10] Although the indications for early surgical intervention are becoming more precisely defined[3,6] reports of successful pulmonary embolectomies using cardiopulmonary bypass remain distressingly few.[1,9] It is, therefore, hoped that this paper may stimulate a more aggressive surgical consideration in the treatment of this disease.

Figure 1, Case 1: Pulmonary angiogram showing complete occlusion of distal right pulmonary artery. The patient's condition did not permit additional studies. Several clots were also removed from the left lung.

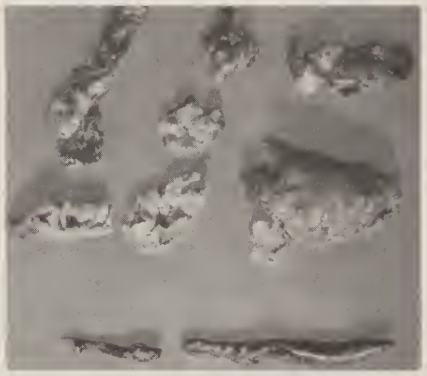


Figure 2, Case 1: Clots removed from pulmonary arteries. Note "casts" of main and lobar branches.

Figure 3, Case 1: Portable roentgenogram of chest showing appearance of excavations in left lung.

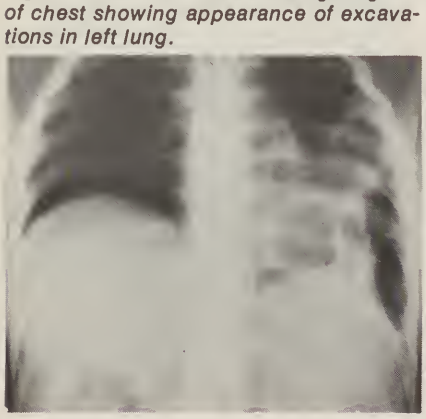
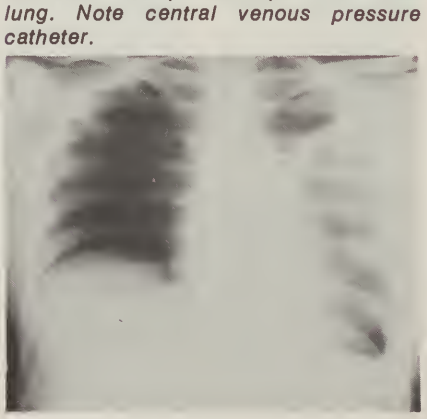


Figure 4, Case 1: Massive left empyema with almost complete compression of left lung. Note central venous pressure catheter.



Case One

A 23-YEAR OLD white woman, D.G., was admitted to the Lankenau Hospital on August [illegible], 1969, with a diagnosis of massive pulmonary embolism. At the time of admission she was deeply cyanotic with distended systemic veins and some ecchymosis. She had been receiving oral contraceptive medication prior to the present illness.

She had been admitted to another hospital approximately eighteen hours previously and treated for "shock of undetermined etiology." She developed progressive systemic hypotension, tachycardia, cyanosis, and rising venous pressure. The diagnosis of massive pulmonary embolus was suggested and angiography carried out. This showed complete occlusion of the right pulmonary artery and the left lower lobe pulmonary artery (Fig. 1). When she arrived at the Lankenau Hospital

igure 5, Case 1: Roentgenogram almost one year postoperatively showing good ex-ansion of pulmonary segments.

ne was taken directly to the operating oom. A median sternotomy was arried out in the usual fashion as well s a right rectus muscle splitting in-ision down to, but not through, the eritoneum. The abdominal incision as loosely packed. Upon entering the iediastinum, a greatly distended right trium and ventricle could be seen rough the pericardium. This was pened longitudinally and a probing eedle in the right atrium recorded a ressure of over 40 mm. Hg. An arteri- infusion catheter was quickly placed the ascending aorta and a single rainage catheter inserted into the ght atrium. Heart-lung bypass was stituted, and after several minutes ie right atrium and right ventricle ecreased markedly in size. After the ght atrium was satisfactorily decom-ressed, a second drainage catheter as inserted and tapes placed about e cavae and tightened. A bypass flow 2.4 liters per square meter of body rface area per minute was es-blished and the patient's temperature duced to 34°C.

The main pulmonary artery was pened longitudinally and found to be rtially filled with clot which ex-nded into the ventricle through the lmonary valve. The clot was easily moved and appeared to represent an most exact cast of the right pulmo-ry arterial tree, including the lobar anches. There was some extension to the left main pulmonary artery ig. 2). Because Fogarty catheters iled to produce additional clot from e left lung, the left pleura was widely pened and the left lung gently ueezed in the hopes of dislodging rther clots. A few additional frag-ents of clot were removed, and the pulmonary artery closed. Heparinization was reversed with protamine sulfate and, as the median sternotomy was closed, the peritoneum previously exposed in the abdominal incision was opened longitudinally and a Miles clip placed around the inferior vena cava just below the renal veins. The wounds were then closed in routine fashion with drainage of the mediastinum and left pleural space.

Postoperative Problems

A stormy postoperative course followed characterized by persistent low pO_2values and arterial oxygen saturations of 70%, with a pCO_2 below 40 mm. Hg. Continuous mechanical ventilation was necessary but at the end of 24 hours the arterial blood gases had returned to normal. The patient, however, remained unconscious. On August 30, 1969, a tracheotomy was performed for continued respiratory insufficiency and retained secretions. A carotid arteriogram was done on September 19, 1970. This showed bilateral subdural hematomata. These were evacuated under local anesthesia and the patient gradually regained consciousness and later became completely awake and alert.

The chest x-ray of September 31, 1970, revealed several translucent areas in the left lung (Fig. 3). Antibiotic therapy failed to resolve the abscesses which increased rapidly in size and by October 22, 1970, the entire left lung was collapsed or replaced with a huge abscess cavity containing an air fluid level (Fig. 4).

The following day, the patient was taken to the operating room where a left posterolateral thoracotomy was carried out. A very large empyema cavity, containing 1,500 cc. of purulent material, was excised including its parietal wall. Three smaller cavities communicating with the large one were also excised and closed intercostal drainage instituted. The postoperative course was remarkedly benign. The patient was discharged from the hospital on November 19, 1969.

She was last seen on September 2, 1970, at which time she appeared in excellent health and symptom free. The chest x-ray at that time showed minimal postoperative changes (Fig. 5).

Case Two

R. McC. was a sixty-eight-year-old man admitted to the Lankenau Hospital emergency room on October 28, 1969. At the time of admission he was extremely dyspneic, cyanotic, and had marked venous distention. Marked orthopnea was apparent and his symptoms were accompanied by tachycardia and restlessness with a sense of impending doom.

Figure 6, Case 2: Shows two frames from pulmonary artery angiogram. The picture on the right shows no perfusion of the left lung. On the left, some perfusion of the right lower lobe is seen.

Figure 7, Case 2: Showing casts removed from pulmonary arteries. Note main and lobar extensions.

The past medical history is significant in that two days prior to admission the patient was discharged from the hospital following a laparotomy on October 18, 1969.

The patient's clinical diagnosis suggested a massive postoperative pulmonary embolus and he was prepared for operation, taken to the radiology department for pulmonary angiography, and thence immediately to the operating room. The pulmonary angiogram showed complete obstruction of the left pulmonary artery as well as occlusion of the right upper and middle lobe arteries. The only significantly profused lobe was the right lower lobe (Fig. 6).

A median sternotomy was quickly performed and, again, a greatly distended right atrium was noted. The ascending aorta was immediately cannulated and a single large drainage catheter placed in the right atrium. Extracorporeal circulation was begun and the patient's temperature lowered to 32°C. Within a few minutes, the right heart had decreased to normal size and a second venous drainage catheter was then inserted. These were treaded into the cavae and taped.

The pulmonary artery was opened longitudinally and a large cast of the left pulmonary artery with its upper lobar branches was removed. Extensions into the right side were also removed in one large piece (Fig. 7). The patient's general condition improved dramatically but because of his age and the magnitude of the procedure it was decided to terminate the operation in the usual fashion without placing a clip on the inferior vena cava.

His postoperative course was remarkably benign and he was well enough to leave the hospital on the 24th postoperative day. The postoperative chest x-ray of November 23, 1970, was within normal limits (Fig. 8).

Comment

It is of interest that the twenty-three year old woman had such a stormy postoperative course and it is suggested that this may have resulted from the presence of an extremely high venous pressure for almost eighteen hours prior to heparinization for cardiopulmonary bypass. It is quite possible during this time that she may have infarcted several areas in her left lung, which subsequently developed into lung abscesses, bronchal-pleural fistulae and empyema. It is also possible that the extremely high and prolonged venous pressure may have resulted in subdural hematomata following heparinization required heart-lung bypass.

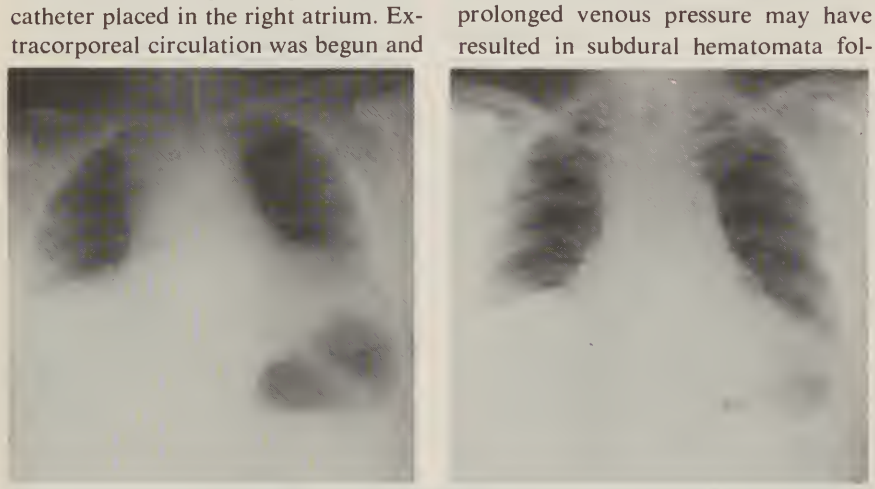


Figure 8, Case 2: The emergency chest roentgenogram on the left was taken at the time of admission. No massive atelectasis or infiltrates are seen. The roentgenogram on the right was taken just prior to discharge from the hospital.

In contrast, the sixty-eight year man had a benign post-operate course suggesting that insufficient ti had elapsed for the changes which predisposed the young woman to development of her distressing com cations.

Summary

Two cases of massive pulmon embolism are presented. One wa twenty-three-year-old woman who been receiving oral contracepti prior to the episode of embolizati The second was a sixty-eight-year- man who sustained massive pulmon embolization ten days following an dominal operation and two days a having been discharged from the h pital. In both, the diagnosis was c firmed by pulmonary angiography a both patients were operated u using the extracorporeal heart-lung paratus. Both patients survived operation, and were discharged fr the hospital well. □

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Penn State—Pennsylvania State University
Temple—Temple University School of Medicine
U. of Pa.—University of Pennsylvania School of Medicine
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CARDIOVASCULAR DISEASES

Sayre; June 28, 1971—February 1, 1972

Rotating Specialty Seminar/Cardiovascular Disease; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 17 weeks; 17 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

DERMATOLOGY

Sayre; August 10, 1971—June 6, 1972

Rotating Specialty Seminar/Dermatology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 6 weeks; 6 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

ENDOCRINOLOGY

Sayre; July 20, 1971—May 23, 1972

Rotating Specialty Seminar/Endocrinology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 9 weeks; 9 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

FAMILY MEDICINE

Hershey; September 28, 1971—June 27, 1972

Newer Aspects of Family Medicine; at Hershey; 1 hr. per day; 1 day per week; 40 weeks; 40 hrs. AAGP credit approved. Contact Thomas L. Leaman, M.D., Chrm., Dept. of Family & Community Medicine, M.S. Hershey, Hershey 17033.

GASTROENTEROLOGY

Philadelphia; March 3 - April 7, 1972

AMA — Gastroenterology Seminar (Basic Concepts in the Modern Diagnosis & Management); at Hahnemann; 3½ hrs. per day; 1 day per week; 6 weeks; 21 hrs. AAGP credit requested; fee = $60. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

GENERAL MEDICINE

Abington Memorial Hospital; September 15—December 1, 1971

Psychiatry for the Family Practitioner; by Montgomery County Academy of Family Practice; 2½ hrs. per day; 1 day per week; 10 weeks; 25 hrs. AAGP credit requested; max. enrollment=30; fee=$25. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Abington Memorial Hospital; January 20—March 21, 1972

Endocrine Problems in Family Practice; by Montgomery County Academy of Family Practice; 2½ hrs. ea. day; 1 day ea. week; 10 weeks; 25 hrs. AAGP credit requested; max. enrollment=30; fee=$25. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Allentown Hospital; September 9, 1971 - June 8, 1972

AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; 1 day ea. mo.; 3 hrs. ea. day; 30 hrs. AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Altoona Hospital; October 7, 1971 - May 18, 1972

AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; 2 days ea. mo.; 2 hrs. per day; AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 16, 1971 - May 18, 1972

AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; at St. Luke's Hosp.; 1 day ea. mo.; 3 hrs. per day; AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford; October 19, 1971 - May 16, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; at Penn Hills Club; third Tues. ea. mo. except Dec. and Jan.; 18 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Chester; September 7, 1971—May 23, 1972

AMA— Continuing Education Program; at Crozer-Chester Med. Center; by Hahnemann; 2 hrs. per day; 1 day per week; 38 weeks; 76 hrs. AAGP credit requested; 76 hrs. ACGP credit approved. Contact Frederick K. Heath, M.D., D.M.E., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Coatesville VA Hospital; September 23, 1971—May 25, 1972

The Laboratory and the Clinician; 1 hr. a day; 1 day per mo.; 9 hrs. AAGP credit requested. Contact John C. Cottrell, M.D., Chief, Laboratory Services, Coatesville VA Hosp., Coatesville 19320.

DuBois Hospital; February 10 - April 13, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; Thurs. ea. week; 30 hrs. AAGP credit requested, fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

East Stroudsburg; October, 1971 - April, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and M.C. of Pa.; at General Hosp. of Monroe County; 3 hrs. per day; 1 day per mo.; 6 mos.; 18 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Easton Hospital, September 15, 1971 - June 21, 1972

AMA— What's New in Basic Concepts of Each Sub-Division of Medicine; by Hahnemann; 1½ hrs. per day; third Wed. ea. mo.; 12 hrs. AAGP credit approved. Contact Horace Y. Seidel, M.D. Dir., Dept. of Medicine, Easton Hosp., 21st & Lehigh Sts., Easton 18042.

Gettysburg; January 11 - April 19, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; Annie Warner Hospital; every-other week, alternating Tues. and Wed.; 24 hrs. AAGP cre requested; fee to be announced. Contact PM (Continuing Education), 20 Erford Rd., Lemoy 17043.

Hanover General Hospital; October 20, 1971 - M 18, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education P gram); by PMS and Susquehanna Valley RMP; c ea. mo. except Jan. and Feb.; 12 hrs. AAGP cre requested. Contact PMS (Continuing Educatio 20 Erford Rd., Lemoyne 17043.

Harrisburg; September 30, 1971—January 20, 19

Continuing Education Program 1971-1972; Community General Osteopathic Hosp.; 8 Thur 2½ hrs. per day; fee=$60 ($10 ea. single se sion); AAGP and ACGP credit requested. Conta Charles M. Worrell, D.O., D.M.E., Community Ge Osteopathic Hosp., 4300 Londonderry Rd., Harr burg 17109.

Hazleton State General Hospital; September 1 June 1

AMA (required credit) — A Program of Co tinuing Medical Education; by U. of Pa.; 1½ h ea. day; Thurs. ea. week; 36 weeks; 54 hrs. tot 40 hrs. AAGP credit approved. Contact Robe Gunderson, M.D., D.M.E., Hazleton State Ge Hosp., Hazleton 18201.

Kittanning; December 2 - 16, 1971

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Pr gram); by PMS, Pitt and Western Pa. RMP; Armstrong County Memorial Hosp.; every Thurs. hrs. AAGP credit requested, fee to be announce Contact William M. Cooper, M.D., Dir. of Co Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Lancaster General Hosp.; September 7, 1971 May 30, 1972

Continuing Education Program; 1 day per wee 3 hrs. per day; 29 days; AAGP credit requeste fee = none. Contact John H. Esbenshade, J M.D., Dir. Med. Educ., Lancaster General Hos 555 N. Duke St., Lancaster 17604.

Lancaster Osteopathic Hospital; September 2 1971 - May 25, 1972

AMA — Continuing Education Program; by Ha nemann; 2 hrs. per day; 1 day per week; 17 week 34 hrs. AAGP and ACGP credit requested. Conta Frederick K. Heath, M.D., Dir., Cont. Educ., Ha nemann, 230 N. Broad St., Philadelphia 19102.

Lebanon; October 7—November 11, 1971

Drug Abuse; by Consult, Inc. (Lebanon C Commission of Drug Abuse) and the Institute Pa. Hosp.; at Lebanon Municipal Bldg.; Thurs. e week; six weeks. Contact Raymond R. Curanz M.D., 39 E. Maple St., Palmyra 17078.

Lebanon; November 3, 1971 - May 2, 1972

AMA — A Continuing Medical Education Pr gram; by Jefferson and Penn State; at Quent Riding Academy; 1 day every-other mo.; 2 hrs. p day; 8 hrs. AAGP credit requested; fee = non Contact John H. Killough, Ph.D., M.D., Assc Dean, Jefferson, 1025 Walnut St., Philadelph 19107.

Lewistown Hospital; February 9 - April 12, 1972

Current Medical and Surgical Concepts Pennsylvania Medical Continuing Education Pr gram); by PMS and Susquehanna Valley RM every Wed.; 30 hrs. AAGP credit requested; fee be announced. Contact PMS (Continuing Educ tion), 20 Erford Rd., Lemoyne 17043.

Lock Haven Hospital; October 20, 1971 - April 1 1972

Current Medical and Surgical Concepts Pennsylvania Medical Continuing Education Pr gram); by PMS and Susquehanna Valley RMP; fir

l third Wed. except holidays; 30 hrs. AAGP dit requested, fee to be announced. Contact S (Continuing Education), 20 Erford Rd., noyne 17043.

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adville; September 1, 1971 - May 3, 1972
Current Medical and Surgical Concepts (A nsylvania Medical Continuing Education Pro- m); by PMS; at Meadville City Hosp.; first Wed. mo.; 18 hrs. AAGP credit requested; fee to be ounced. Contact PMS (Continuing Education), Erford Rd., Lemoyne 17043.

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iladelphia; September 15, 1971 - May 17, 1972
Continuing Medical Education Seminars; at thodist Hospital; 1 day ea. mo.; 2 hrs. per day; hrs. AAGP credit requested; fee = none. Con- t John N. Giacobbo, M.D., D.M.E., Methodist sp., 2301 S. Broad St., Philadelphia 19143.

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iladelphia; October 13 - December 1, 1971
Recent Advances in Medicine; at Temple; 1 day week; 4½ hrs. ea. day; AAGP credit uested; fee=$75. Contact Albert J. Finestone, D., Dept. of Med., Temple, Broad & Ontario s., Philadelphia 19140.

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iladelphia; January 4 - May 16, 1972
AMA— Current Topics of Interest to the Family ysician; at Jefferson; 2 hrs. per day; 1 day per ek; 20 weeks; 40 hrs. AAGP credit requested; e=$150. Contact John H. Killough, Ph.D., M.D., soc. Dean, Jefferson, 1025 Walnut St., iladelphia 19107.

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Post Graduate Medical Education Lectures; at . Margaret Memorial Hosp.; first, second and ird Thurs. ea. mo. except July; 1 hr. per day; AGP credit requested; min. enrollment=30; e=none. Contact Paul W. Dishart, M.D., D.M.E., . Margaret Memorial Hosp., 265 - 46th St., Pitts- rgh 15201.

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ttsburgh; September 2, 1971 - June 15, 1972
Psychiatry Seminars in Family Practice; at St. argaret Memorial Hosp.; 1 day ea. week; 2 hrs. a. day; 32 weeks; min. enrollment 6; AAGP credit quested; fee=$50 for ea. 10-week series. Con- ct Paul W. Dishart, M.D., D.M.E., St. Margaret emorial Hosp., 265 46th St., Pittsburgh 15201.

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ittsburgh; October 21, 1971 - June 1, 1972
Seminars for the Primary Physician; at Pitt; 2 s. ea. evening; 1 day per week; 27 weeks; 54 s. AAGP credit requested; fee=$10 per session 150 for all 27). Contact William M. Cooper, M.D., ir., Div. of Cont. Educ., Pitt, 1022-H Scaife Hall, ittsburgh 15213.

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ittsburgh; July 14, 1971 - June 23, 1972
Post Graduate Medical Education Lectures -Family Practice; at St. Margaret Memorial osp.; every Wed.; 1 hr. ea. day; AAGP credit equested; min. enrollment=20; fee=none. Con- ct Paul W. Dishart, M.D., D.M.E., St. Margaret lemorial Hosp., 265 - 46th St., Pittsburgh 15201.

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ottsville Hospital; September 2, 1971 - June 1, 972
AMA —A Program of Continuing Medical Edu- ation; by Jefferson and Penn State; first Thurs. a. mo.; 2 hrs. ea. day; 20 hrs. AAGP credit pproved; fee=none. Contact John H. Killough, h.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut t., Philadelphia 19107.

Reading; September 28, 1971—May 23, 1972
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St. Marys; September 26, 1971 - March 26, 1972
Current Medical and Surgical Concepts (An Ed- ward Walter Clark Memorial Education Program of the Educational and Scientific Trust); by PMS, Pitt and Western Pa. RMP; at Andrew Kaul Memorial Hosp.; forth Sun. ea. mo. except December; 21 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Scranton; Fourth Wednesday of each month (except November, December & June)
A Program of Continuing Medical Education; at Casey Inn; by Lackawanna Co. Med. Society and Greater Delaware Valley RMP; 3 hrs. ea. evening; AAGP credit requested. Contact R.N. Shoemaker, Ph.D., Coordinator of Med. Educ., VA Hosp., 1111 E. End Blvd., Wilkes-Barre 18703.

Sellersville; September 22, 1971 - June 15, 1972
AMA —Continuing Education Program; at Grand View Hosp.; by Hahnemann; 2 hrs. per day; 1 day per mo.; 9 months; 18 hrs. AAGP and ACGP credit requested. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Sharon General Hospital; October 20, 1971 March 1, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; first and third Wed. ea. mo.; 30 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Somerset Community Hospital; Fourth Tuesday of each month
A Program of Continuing Medical Education; by Western Pa. RMP and the Regional PG Medical Faculty Project of Lee Hospital, Johnstown; 2 hrs. ea. day; 24 hrs. AAGP credit requested ea. year. Contact William W. Ayres, M.D., Pathologist, Somerset Community Hosp. 225 S. Center Ave., Somerset 15501.

Tunkhannock; March 8 - May 10, 1972
Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust); by PMS and Greater Delaware Valley RMP; at Tyler Memorial Hosp.; second Wed. ea. mo.; 9 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Uniontown Hospital; September 22, 1971 - February 23, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; every-other Wed. except Dec. and Jan.; 24 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Wellsboro; September 15, 1971 - March 15, 1972
Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust) by PMS and Susquehanna Valley RMP; at Soldiers and Sailors Memorial Hosp.; third Wed. every-other mo.; 12 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Wilkes-Barre; September 15—October 27, 1971
AMA— Continuing Education Program; at Wyoming Valley Hosp.; by Hahnemann; 3½ hrs. per day; 1 day per week; 6 weeks; 21 hrs. AAGP credit requested, ACGP credit approved; fee=none. Contact Frederick K. Heath, M.D., D.M.E., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Williamsport Hospital; September 10, 1971 - March 10, 1972
AMA — A program of Continuing Medical Education; by Jefferson and Penn State; second Fri. ea. mo. except Jan.; 3 hrs. ea. day; 18 hrs. AAGP credit requested; fee=none. Contact John H. Killough, Ph. D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

HEMATOLOGY

Sayre; July 12, 1972—June 5, 1972
Rotating Specialty Seminar/Hematology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 15 weeks; 15 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

INTERNAL MEDICINE

Abington Memorial Hospital; September 2—December 16, 1971
S-Recent Advances in Internal Medicine; 2 hrs. per day; 1 day per week; 15 weeks; max. enrollment=40 (internal medicine); fee=$30. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Philadelphia; October 6, 1971 - May 31, 1972
AMA — Internal Medicine Reviews; at Hahnemann; 3 hrs. ea. day; 1 day ea. week; 32 weeks; 96 hrs. AAGP credit approved; $175 fee ($50 ea. sub-specialty — Hematology & Medical Oncology, October 6 to November 17; Gastroenterology, November 24, 1971 to February 9, 1972, Dermatology & General Topics, February 16 to April 19; Cardiology, April 26 to May 31). Contact Mrs. Sage Cordell, Asst. Dir. PG Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Pittsburgh; September 13 - October 15, 1971
AMA — Internal Medicine Review Course; by Pitt and Amer. Coll. of Physicians; at Pitt; 3 hrs. a day; 2 day ea. week; 5 weeks; 33 hrs. AAGP credit requested; $50 fee. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt. Scaife Hall, Pittsburgh 15213.

MALIGNANT DISEASE

Reading; Fourth Tuesday ea. month
Tumor Conference; at Community General Hospital. Contact Harold I. Farber, M.D., Dir. Tumor Clinic, Community Gen. Hosp., 145 N. Sixth St., Reading 19601.

NEPHROLOGY

Sayre; September 13, 1971—May 29, 1972
Rotating Specialty Seminar/Nephrology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 9 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Norristown State Hospital; September 13, 1971 - May 8, 1972
Intensive Review of Neurology; 1¼ hrs. per day; 1 day per week; 30 weeks; min. enrollment 8; fee=$100. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

NEUROLOGY

Sayre; August 9, 1971—March 21, 1972
Rotating Specialty Seminar/Neurology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 9 weeks; 9 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

OBSTETRICS & GYNECOLOGY

Pittsburgh; (dates by arrangement)
Workshops in Family Planning; by Pitt; at Magee-Womens Hosp.; 3½ hrs. per day; 1 day per week; two successive Fridays; 7 hrs. AAGP credit requested; fee=$50. Contact Marvin C. Rulin, M.D., Magee-Womens Hosp., 3400 Forbes St., Pittsburgh 15213.

OPHTHALMOLOGY

Abington Memorial Hospital; September 22, 1971—May 22, 1972
S-Recent Trends on Ophthalmology; 1½ hrs. per day; 1 day per mo.; 9 mos. 13 hrs. total; max. enrollment=15; fee=none. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

PHARMACOLOGY

Philadelphia; September 27, 1971 - January 24, 1972
AMA — Experimental Design, Statistics and Fortran; at Hahnemann; 2 hrs. per day; 2 days per week; 15 weeks; 58 hrs. AAGP credit requested; fee=$300. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia General Hospital; September 29, 1971 - May 31, 1972

AMA — Current Concepts in Clinical Pharmacology; by Hahnemann and American Society for Clinical Pharmacology and Therapeutics; 3 hrs. per day; 1 day per week; 35 weeks; 105 hrs. AAGP credit requested; fee=none. Contact

Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

PSYCHIATRY

Abington Memorial Hospital; September 27, 1971—June 12, 1972

S-Seminar in Psychiatry; 1½ hrs. per day; 2nd and 4th Mon. ea. mo., 10 mos.; max. enrollment=30; fee=none. Contact William H. Mahood, M.D., Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Abington Memorial Hospital; March 7—May 9, 1972

S-Marital Therapy; 2 hrs. per day; 1 day per week; 10 weeks; max. enrollment=20; fee=$50. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Allentown Osteopathic Hospital; September 22 - December 8, 1971

AMA — Adolescence and the Youth Culture; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks; 20 hrs. AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Carlisle Hospital; September 24 - October 22, 1971

AMA— New Dimensions in Patient Care; by The Institute of Pa. Hosp. and PMS; 2 hrs. per day; 1 day per week; 5 weeks; 10 hrs. AAGP credit requested; fee=$25. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Danville; September 8, 1971 - April 12, 1972

AMA— Psychiatry and Community Mental Health; at Geisinger Med. Center; by The Institute of Pa. Hosp., PMS and PAGP; 2 hrs. per day; 1 day per week; 5 weeks; 12 hrs. AAGP credit requested; fee=$5. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Easton Hospital; September 27, 1971 - June 26, 1972

AMA — Psychiatry in Medical Practice; by Hahnemann; 1½ hrs. per day; 1 day per mo.; 9 mos.; 13½ hrs. AAGP credit requested; fee=none. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Lancaster General Hospital; October 20 - November 17, 1971

AMA— Drug Abuse and Alcoholism; by The Institute of Pa. Hosp., PMS and PAGP; 2 hrs. per day; 1 day per week; 5 weeks; 10 hrs. AAGP credit requested; no fee. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Lebanon; October 7 - November 11, 1971

AMA— Drug Abuse and Alcoholism; at Municipal Bldg.; by The Institute of Pa. Hosp., PMS and PAGP; 2 hrs. per day; 1 day per week; 6 weeks; 12 hrs. AAGP credit requested; fee=$25. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Norristown State Hospital; September 10, 1971 - May 12, 1972

S — Intensive Review of Psychiatry; 1¼ hrs. per day; 1 day per week; 31 weeks; min. enrollment=8; fee=$100. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown State Hospital; October 1 - December 10, 1971

S — Group Therapy; 1½ hrs. per day; 1 day per week; 10 weeks; min. enrollment=8; fee=$50. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown State Hospital; January 7 - February 18, 1972

S — Management of Adolescent Behavorial Disorders; 1½ hrs. per day; 1 day per week; 7 weeks; min. enrollment=8, fee=$30. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown State Hospital; March 3 - May 19, 1972

S — Family Therapy II; 1½ hrs. per day; 1 day per week; 10 weeks; min. enrollment=8; fee=$50. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown; (dates to be announced)

AMA— Drug Abuse and Alcoholism; at Montgomery Co. Mental Health Clinics; by The Institute of Pa. Hosp., PMS and PAGP; 2 hrs. per day; 1 day per week; 12 weeks; 24 hrs. AAGP credit requested; fee=$25. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; September 7, 1971 - June 6, 1972

S/AMA — Advances in Psychiatry and Behavorial Sciences; by Institute of Pa. Hosp. and U. of Pa.; at the Institute; 1½ hrs. ea. day; 1 day ea. mo.; 10 mos.; fee=$50. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; September 15 - November 17, 1971

AMA — Sexual Problems in Medical Practice; by Hahnemann; 2 hrs. ea. day; 1 day ea. week; 10 weeks; AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 4 - December 6, 1971

S/AMA — Family Therapy; by the Institute of Pa. Hosp. and U. of Pa.; at Philadelphia Child Guidance Clinic; 2½ hrs. per day; 1 day per week; 10 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 6 - December 8, 1971

S/AMA — Marital Therapy; by the Institute of Pa. Hosp. and U. of Pa.; at Marriage Council of Philadelphia; 2½ hrs. ea. day; 1 day per week; 10 weeks; fee =$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 6, 1971 - February 16, 1972

AMA — Psychiatric Problems of Children; by Hahnemann; 2 hrs. per day; 1 day per week; 18 weeks; 36 hrs. AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Edu. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 7 - November 11, 1971

AMA— Sensitivity Training for Medical Practitioners; at The Institute of Pa. Hosp.; by The Institute, PMS and PAGP; 3 hrs. per day; 1 day per week; 6 weeks; 18 hrs. AAGP credit requested; fee=$35. Contact Sydney E. Pulver, M.D., Dir., The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 7, 1971 - February 17, 1972

AMA— Medical Hypnosis; at The Institute of Pa. Hosp.; by The Institute, PMS and PAGP; 4 hrs. per day; 1 day per week; 20 weeks; 80 hrs. AAGP credit requested; fee=$150. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 13, 1971 - May 17, 1972

AMA — Seminars in Psychotherapy: Short-term, Crisis & Supportive Therapies; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks per seminar; AAGP credit requested; fee=$150 for 30 weeks, $75 for 10 weeks. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; December 2, 1971 - April 20, 1972

AMA— New Dimensions in Patient Care; by The Institute of Pa. Hosp., PMS and PAGP; at The Institute; 2 hrs. per day; 1 day per week; 18 weeks; 36 hrs. AAGP credit requested; fee=$100. Con
Sydney E. Pulver, M.D., Dir., The Institute of
Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 10 - March 13, 1972

S/AMA — Behavior Therapy; by the Institute
Pa. Hosp. and U. of Pa.; at Hospital of U. of Pa
hrs. per day; 1 day per week; 10 weeks; fee=$1
Contact Peter B. Bloom, M.D., Coordinator, C
Educ. for Psychiatrists, The Institute of Pa. Ho
111 N. 49th St., Philadelphia 19139.

Philadelphia; January 10 - February 14, 1972

S/AMA — Psychopharmacology; by the Instit
of Pa. Hosp. and U. of Pa.; 1½ hrs. per day; 1
per week; 6 weeks; fee=$100. Contact Peter
Bloom, M.D., Coordinator, Cont. Educ. for Psyc
atrists, The Institute of Pa. Hosp., 111 N. 49th
Philadelphia 19139.

Philadelphia; January 11 - February 29, 1972

S/AMA — Treating Today's Adolescent; by
Institute of Pa. Hosp. and U. of Pa.; 1½ hrs.
day; 1 day per week; 8 weeks; fee=$100. Cont
Peter B. Bloom, M.D., Coordinator, Cont. Educ.
Psychiatrists, The Institute of Pa. Hosp., 111
49th St., Philadelphia 19139.

Philadelphia; March 22 - May 24, 1972

AMA — Adolescence and the Youth Culture;
Hahnemann; 2 hrs. per day; 1 day per week;
weeks; AAGP credit requested; fee=$75. Cont
Paul Jay Fink, M.D., Dir. of Educ. & Trainir
Dept. of Mental Health Sciences, Hahnemann, 2
N. Broad St., Philadelphia 19102.

Philadelphia; March 22 - May 24, 1972

S/AMA — Advanced Marital Therapy — Treati
Sexual Incompatibility; by the Institute of
Hosp. and U. of Pa.; at Marriage Council
Philadelphia; 2½ hrs. per day; 1 day per week;
weeks; fee=$100. Contact Peter B. Bloom, M.
Coordinator, Cont. Educ. for Psychiatrists, The
stitute of Pa. Hosp., 111 N. 49th St., Philadelp
19139.

Sayre; July 27, 1971—May 8, 1972

Rotating Specialty Seminar/Psychiatry; at Ro
ert Packer Hosp.; 1 hr. per day; 1 day per week;
weeks; 10 hrs. AAGP credit approved. Cont
Paul C. Royce, M.D., Ph.D., D.M.E., Robert Pack
Hosp., Guthrie Square, Sayre 18840.

Scranton; September 29 - December 8, 1971

AMA— New Dimensions in Patient Care; at
Casey Inn; by The Institute of the Pa. Hosp., P
and PAGP; 2 hrs. per day; 1 day per week;
weeks; 24 hrs. AAGP credit requested; fee=$
Contact Sydney E. Pulver, M.D., Dir., The Institu
of the Pa. Hosp., 111 N. 49th St., Philadelp
19139.

OTHER COURSES
code

C—Continuous (Consecutive Days)
O—One Day or Less
PG—Postgraduate Traineeship
M—Multiple Sites (Circuit)

ALLERGY

September 6 - October 29, 1971; Philadelphia
(repeat February 7 - March 13, 1971 and May 1
June 23, 1972)

PG/AMA — Clinical Immunology Tutoria
Course; at Hahnemann; 7-8 hrs. per day; 40 days
fee = $500. Contact Frederick K. Heath, M.D.
Dir., Cont. Educ., Hahnemann, 230 N. Broad St.
Philadelphia 19102.

ARTHRITIS & RHEUMATISM

Continuous; Philadelphia

PG/AMA — Rheumatology Tutorial Course; at
Hahnemann; 6-7 hrs. per day; 2 days per week; 4
weeks; fee = $150. Contact Frederick K. Heath,
M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad
St., Philadelphia 19102.

CARDIOVASCULAR DISEASE

Continous (2 or 3 weeks in each sub-section);
Philadelphia

PG/AMA — Tutorial Courses; Fluid and Electro-
te Metabolism; Hypertension (Clinical & Labora-
ory); Dialysis; Cardio-Hemodynamics; Cardiac
are Unit; Electrophysiology; Vector-Electrocar-
iography and Cardiovascular Pharmacology;

therosclerosis and Lipid Metabolism; Phono-
cho; Clinical Cardiology and Cardiovascular Sur-
ery; at Hahnemann; 6, 7, 8, or 9 hrs. per day; 10
r 15 days; fee = $300 ea. sub-section. Contact
rederick K. Heath, M.D., Dir., Cont. Educ., Hah-
emann, 230 N. Broad St., Philadelphia 19102.

eptember 21 - 25, 1971; Philadelphia
C/AMA — Cardiac Arrhythmias (Pathophysio-
gy, Pharmacology and Treatment by Hah-
emann; at Marriott Motor Hotel; 7 hrs. ea. day;
½ days; 30 hrs. AAGP credit approved; $175 fee.
ontact Mrs. Sage Cordell, Asst. Dir., Cont. Educ.,
ahnemann; 230 N. Broad St., Philadelphia 19102.

eptember 27 - 28, 1971; Philadelphia
C/AMA — Current Topics in Cardiopulmonary
isease - 1971; Evolving Concepts in Coronary Ar-
ry Disease; by American College of Cardiology;
t Temple. Contact Miss Mary Ann McInerny, Dir.,
ept. of Cont. Educ., American College of Car-
iology, 9650 Rockvill Pike, Bethesda, Md. 20014.

larch 16-17, 1972; Philadelphia
C— Cardiopulmonary Resuscitation Instructors'
raining Course; at Emergency Care Research In-
itute; by Pa. Heart Assoc. and Heart Assoc. of
outheastern Pa.; 7 hrs. ea. day; fee=$40. Con-
ct Emergency Care Research Inst., 913 Walnut
., Philadelphia 19107.

ctober 28-29, 1971; Hershey
C— Cardiopulmonary Resuscitation Instructors'
raining Course; at Hershey; by Pa. Heart Assoc.
nd South Central Pa. Heart Assoc.; 7 hrs. ea. day,
e=$40. Contact Royce J. Britton, Prgm. Dir., Pa.
eart Assoc., 2743 N. Front St., Harrisburg 17105.

ovember 2-3, 1971; Pittsburgh (repeat starting
larch 21 and June 6, 1972)
C— Cardiopulmonary Resuscitation Instructors'
raining Course; at Pitt; by Pa. Heart Assoc. and
Vestern Pa. Heart Assoc.; 7 hrs. per day; 2 days;
e=$40. Contact Div. of Cont. Educ., Pitt, 1022-H
caife Hall, Pittsburgh 15213.

ecember 13-17, 1971; Philadelphia
C/AMA — High Blood Pressure, 1971 (26th Hah-
emann Symposium); by Hahnemann; at Sheraton
otel; 7 hrs. per day; 5 days; 35 hrs. AAGP credit
pproved; fee = $175. Contact Frederick K.
eath, M.D., Dir., Cont. Educ., Hahnemann, 230 N.
road St., Philadelphia 19102.

March 13-15, 1972; Philadelphia
C/AMA— Non-Invasive Technique in Evaluation
f Cardiac Function; at U. of Pa.; by American
leart Assoc., Pa. Heart Assoc. and Heart Assoc.
f Southeastern Pa.; fee (for Fellows)— $60. Con-
act Miss Carole Mintz, Dept. of Med. Ed., Ameri-
an Heart Assoc., 44 E. 23rd St., New York City
0010.

pril 10-21, 1972; Philadelphia
C/AMA — Core Curriculum-Fundamentals and
pplied Clinical Cardiology Seminar; by Hah-
emann; 7 hrs. per day; 12 days; 84 hrs. AAGP
redit requested; fee = $300. Contact Frederick
. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230
. Broad St., Philadelphia 19102.

uly 17-19, 1972, Philadelphia
C/AMA — Bedside Diagnosis of Heart Disease;
y Hahnemann; 7 hrs. per day; 3 days; 21 hrs.
AGP credit requested; fee = $125. Contact
rederick K. Heath, M.D., Dir., Cont. Educ., Hah-
emann, 230 N. Broad St., Philadelphia 19102.

CHEST DISEASES

ontinuous (4 weeks in each sub-section);
hiladelphia
PG/AMA — Tutorial Courses: Clinical Pulmo-
ary Disease; Inhalation Therapy; Pulmonary
hysiology; Respiratory Intensive Care; at Hah-
emann; 7, 8, or 9 hrs. per day; 20 days; fee =
350. Contact Frederick K. Heath, M.D., Dir., Cont.
duc., Hahnemann, 230 N. Broad St., Philadelphia
9102.

October 4-15, 1971; Wilkes-Barre General Hospital
December 6-17, 1971; Philadelphia (Hahnemann)
March 14-25, 1972; Allentown Hospital
M/AMA — A Workshop in Respiratory Intensive Care; by Greater Delaware Valley RMP: 2 weeks; 5 days ea. week; 70 hrs. AAGP credit approved. Contact F. R. Johnston, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 24 - 28, 1971; Philadelphia
C/AMA — 37th Annual Fall Scientific Assembly; American College of Chest Physicians; at Sheraton Hotel; 31 credit hours; Fee: Members = no charge; non-members with M.D. degree prior to 1961 = $65 (armed service or US PHS = $45); non-members with M.D. degree received after 1960 = $45 (armed service or US PHS = $25). Contact Bradford W. Claxton, M.Ed., Dir. Cont. Educ., Amer. Coll. of Chest Phys., 112 E. Chestnut St., Chicago, Ill. 60611.

November 1-12, 1971; Philadelphia (repeat February 28 — March 10, 1972)
PG — Bronchoesophagology; at Temple; $350 fee; planned for chest physicians, thoracic surgeons, anesthesiologists and gastroenterologists. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

November 10, 1971; Franklin
O/AMA — A program of Continuing Medical Education; by Jefferson and Penn State; at Franklin Hospital and Voyager Motor Inn; 3 hrs. AAGP credit approved; fee = $10. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 3-6, 1972; Philadelphia
C/AMA — Pulmonary Care in the Seventies (27th Hahnemann Symposium); by Hahnemann; at Marriott Motor Hotel; 5-6 hrs. per day; 4 days; 25 hrs. AAGP credit approved; fee = $175. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

November 14, 1971- Scranton
O— Emergency Medicine; at Sheraton Motor Inn; by Lackawanna Co. Med. Society and the Greater Delaware Valley RMP; 6 hrs. AAGP credit approved; no fee. Contact R.N. Shoemaker, Ph.D., Coordinator of Med. Educ., VA Hosp., 1111 E. End Blvd., Wilkes-Barre 18703.

February 7-18, 1972; Philadelphia (repeat May 2-13, 1972)
PG/AMA — Emergency Room Tutorial Course; by Hahnemann; 8 hrs. ea. day; 10 days; fee=$400. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

March 11, 1972; Hershey
O/AMA — Emergency Room Techniques; by PMS and Pa. Trauma Committee of ACS; at Hershey; 6 hrs.; min. enrollment=50; fee=$10. Contact PMS (Emergency Med. Service), 20 Erford Rd., Lemoyne 17043.

ENDOCRINOLOGY

March 6-31, 1972; Philadelphia
PG/AMA — Endocrinology and Metabolism Tutorial Courses; at Hahnemann, 7-8 hrs. per day; 20 days; fee=$350. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

GASTROENTEROLOGY

April 15, 1972; Hershey
O — Seminar on Gastroenterology; by PMS and Pa. Osteopathic Assoc.; at M.S. Hershey; 6 hrs. AAGP and ACGP credit requested; fee=$100; min. enrollment=20. Contact PMS (PMS-POA Seminar), 20 Erford Rd., Lemoyne 17043.

GENERAL MEDICINE

Continuous; Philadelphia
PG/AMA — Tutorial Courses: Basic General Medicine (7-8 hrs. per day; 60 days; fee=$700); Critical Care Medicine (8-9 hrs. per day; 10 days; fee=$300) at Hahnemann. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

As Requested, 1971; Philadelphia
PG — Acute Care Medicine Fellowship (retraining program for women physicians); by M.C. of Pa.; 6 hrs. per day; 1 yr. duration. Contact Ethel Weinberg, M.D., Assoc. Dean, MCP, 3300 Henry Ave., Philadelphia 19129.

Third Wed. ea. mo.; Aliquippa-Rochester Hospitals (rotation)
Fourth Thurs. ea. mo.; Altoona Hospital
First Tues. ea. mo.; Greensburg (Westmoreland Hosp.)
First Thurs. ea. mo.; Johnstown (Conemaugh Valley Mem. Hosp.)
Second Tues. ea. mo.; Natrona Heights (Allegheny Valley Hosp.)
Last Mon. ea. mo.; Uniontown Hospital
First Wed. ea. mo.; Washington Hospital
M — Diagnosis and Management of Hypertension; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin P. Shapiro, M.D., Project Dir., 501 Flannery Bldg., 3530 Forbes Ave., Pittsburgh 15213.

October, 1971; Altoona
October, 1971; Greensburg
November, 1971; Scranton
November, 1971; Williamsport
January, 1972; Allentown
January, 1972; King of Prussia

M — The Physician and Addictive Disease; by PMS, PAGP, Pa. Dept. of Health and Pa. Dept. of Welfare; 8 hrs. AAGP credit requested; min. enrollment=10, fee=$10. Contact PMS, 20 Erford Rd., Lemoyne 17043.

ORTHOPEDICS

November 10-12, 1971; Philadelphia
C/AMA— Hand Surgery; at Jefferson; 7 hrs. per day; 3 days; 21 hrs. AAGP credit requested; minimum registration=50; fee=$100. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 8-11, 1971; Lancaster
C/AMA — Clinical Therapeutics 1971: Emergency Medicine; by PMS, U. of Pa., Temple, M.C. of Pa. and Hershey; at Host Farm Resort Motel; 24 hrs. AAGP credit requested; min. enrollment=25; fee=$25. Contact PMS (Scientific Assembly), 20 Erford Rd., Lemoyne 17043.

December 13-17, 1971; Philadelphia
C/AMA — High Blood Pressure - 1971; by Hahnemann; at Sheraton Hotel; 8 hrs. ea. day; 4½ days; 35 hrs. AAGP credit requested; $125 fee. Contact Mrs. Sage Cordell, Asst. Dir., Cont. Educ., 230 N. Broad St., Philadelphia 19102.

May 4-6, 1972; St. Davids
C — Annual Main Line Conference of Bryn Mawr Hosp.; at Treadway Inn; 2½ days; 15 hrs. AAGP credit approved; fee=$35. Contact Theodore J. Berry, M.D., DME, Bryn Mawr Hosp., Bryn Mawr 19010.

INTERNAL MEDICINE

January 3-7, 1972; Philadelphia
C/AMA — Workshops in the Physiology, Pathophysiology and Diagnosis of Disorders of Electrolyte and Acid-Base Metabolism; by Amer. Coll. of Physicians; at Hospital of the U. of Pa.; Fee: Members and F.A.C.P. =$80, non-members = $125, candidate members and ACP Latin American Fellows = $40. Contact Registrar, Postgraduate Courses, Amer. Coll. of Physicians, 4200 Pine St., Philadelphia 19104.

March 20-24, 1972; Philadelphia
C/AMA — Specifically Treatable Diseases (Emphasizing Pathophysiology and Early Clinical Findings); by Amer. Coll. of Physicians; at Pennsylvania Hosp. and U. of Pa.; Fee: Members and F.A.C.P.=$80, non-members=$125, candidate members and ACP Latin American Fellows=$40. Contact Registrar, Postgraduate Courses, Amer. Coll. of Physicians, 4200 Pine St., Philadelphia 19104.

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LIPO-NICIN®/100mg.
Each blue tablet contains:

Nicotinic Acid	100 mg.
Niacinamide	75 mg.
Ascorbic Acid	150 mg.
Thiamine HCl (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCl (B-6)	10 mg.

DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

NOT TIMED
LIPO-NICIN®/250mg.
Each yellow tablet contains:

Nicotinic Acid	250 mg.
Niacinamide	75 mg.
Ascorbic Acid	150 mg.
Thiamine HCl (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCl (B-6)	10 mg.

DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

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Each capsule contains:

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Vitamin C (Ascorbic Acid)	150 m
Vita. B1 (Thiamine HCl)	25 m
Vitamin B2 (Riboflavin)	2 m
Pyridoxine HCl (B-6)	10 m

DOSE: 1 to 2 capsules daily.
AVAILABLE: Bottle of 100, 1000.
In a special base so prepared th the active ingredients are release over a period of 6 to 8 hours.

SIDE EFFECTS: Flushing with heat and itching, in some cases followed by sweating, naus and abdominal cramps. This reaction is usually transient. Nausea caused by high acidity c be relieved by non-absorbable antacid. **REFERENCES: 1.** *Parsons, W.B., Jr. — Interview M Trib. Nov. 28-29, 1964.* **2.** *Cohen, D., JAMA, Aug. 6, 1960, Vol. 173, No. 14, P. 1563.*

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1074 Greentree Road, Pittsburgh 15220 Telephone: 412-531-4226

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PENNSYLVANIA MEDICINE classifieds

PHYSICIANS WANTED

Accident Ward Physicians Wanted: for Delaware County Memorial Hospital, Drexel Hill, Pa. Call or write Administrator. Tel: (215) 259-3800.

Regional Medical Program located in Central Pennsylvania interviewing for director (Doctor of Medicine.) Program and core budget in excess of $600,000. Excellent fringe benefits. Send curriculum vitae to RMP, P.O. BOX 301, Lemoyne, Pennsylvania 17043.

To head Child Psychiatric Services in progressive expanding comprehensive Mental Health Center in the city of Philadelphia. Dynamic, creative, imaginative and daring individual wanted. Should be willing to explore group approaches to treatment and participate in related services of consultation to the community. Familiarity with the work of comprehensive mental health centers desirable but not mandatory. Fringe benefits. Northeast Community Mental Health Center, Roosevelt Blvd. & Adams Ave., Tel: (215) 743-1600, Personnel Department.

Emergency Room Physician — Full Time; Accredited 325 bed general hospital active approved internship and residency programs; excellent benefits. Submit resume to: Administrator, Robert Packer Hospital, Sayre, Pa. 18840.

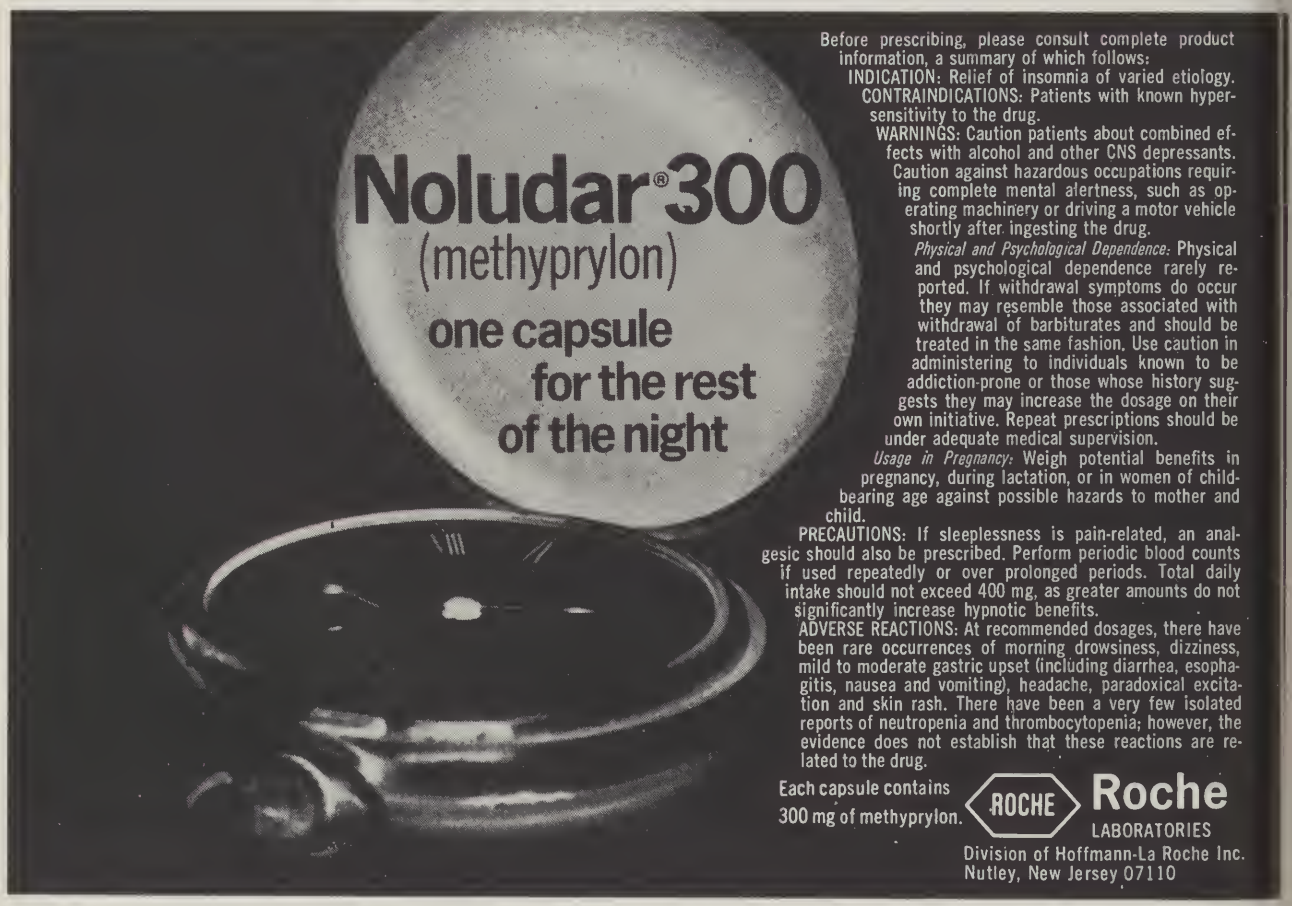
General or Family Practitioners needed— to locate in Northeastern Pa. Excellent opportunity to join a five-man group practicing comprehensive medicine. Located in Endless Mountains. Hunting, fishing, boating and skiing. Three hours from metropolitan areas. Affiliated with private hospital, fully accredited, and modern extended care facility. Contact Eudora S. Bennett, R.N., Administrator, Montrose General Hospital, Montrose, Pa. 18801. Telephone collect: (717) 278-3801.

Emergency Room Physicians—o provide four-man team coverage, 5 bed hospital. Present hospital to be replaced by $22 million medical ce r now under construction. Write P. Pollick, president, Pottstown Memcal Medical Center, P.O. Box 739, Pstown, Pa. 19464.

Internist— Certified. Large corpation's well equipped medical offis. Evaluation and care of domestic d overseas personnel. No travel. Regr hours. $35M salary. Pennsylva license required. Write Box 594 Pesylvania Medicine, 20 Erford R.. Lemoyne, Pa. 17043. Equal Opportity Employer.

POSITION WANTED

Anesthesiologist— 37, board eligle seeking anesthesia position. Pennlvania and West Virginia license. Plse send information to Box 595, Pennlvania Medicine, 20 Erford R.. Lemoyne, Pa. 17043.



1971 SCIENTIFIC ASSEMBLY

"CLINICAL THERAPEUTICS—1971: EMERGENCY MEDICINE"

Host Farm Resort Motel, Lancaster
November 8-11

MORNING SEMINARS

Monday

"Emergencies Associated with Renal and Electrolyte Disorders"

organized by: University of Pa. School of Medicine

Tuesday

"The Unconscious Patient"

organized by: Temple University Medical School

Wednesday

"Emergencies Due to Infections"

organized by: The Medical College of Pennsylvania

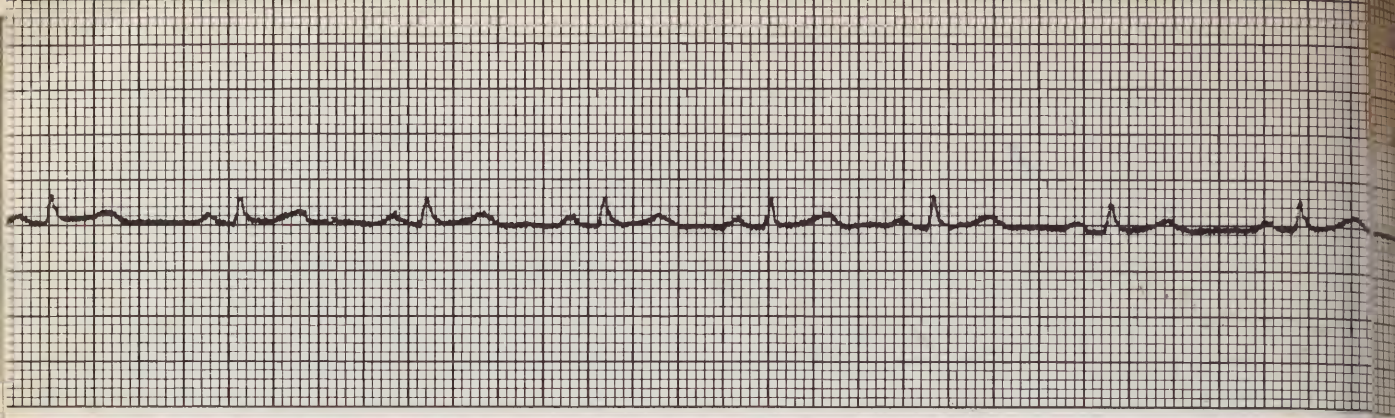
Thursday

'Emergencies Due to Pulmonary Problems

Plus: 16 specialty seminars
4 seminars for nurses & allied professionals

organized by: Pa. State University College of Medicine, Milton S. Hershey Medical Center

for more information contact: J. Reed Babcock, M.D., Chairman, Adv. Cmte. on Cont. Educ.
Pennsylvania Medical Society, 20 Erford Rd., Lemoyne 17043.



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) 2-mg, 5-mg, 10-mg tablets

helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose™ packages of 1000.

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Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

PENNSYLVANIA MEDICINE

NOVEMBER 1971

W 1
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READING ROOM

1971 Annual Session

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Address of George P. Rosemond, M.D. - Page 63
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Assessing the Quality of Medical Care - Page 60
Newer Tests of Thyroid Function - Page 57

Patients fell asleep quickly

Dalmane (flurazepam HCl) 30 mg reduced awake time—both before and after falling asleep - by fifty percent of pretreatment values in patients with insomnia.[1,2]

Two sleep laboratory studies recently confirmed findings of earlier studies of this type, namely, that Dalmane 30 mg was effective in patients who had trouble falling asleep, staying asleep or both. One 30-mg capsule of Dalmane usually induced sleep within 22 minutes, decreased the number of awakenings and the wake time after the onset of sleep, and provided 7 to 8 hours of sleep without need to repeat dosage during the night.

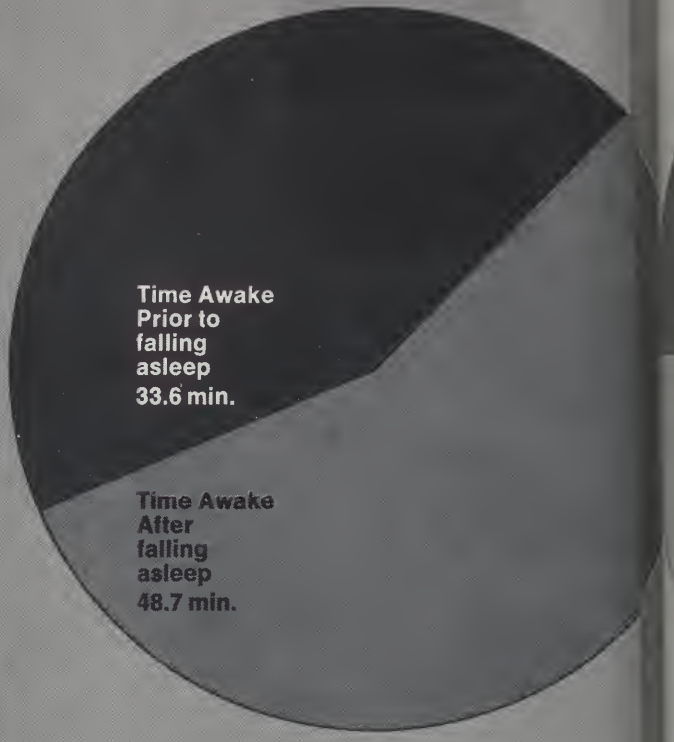
These studies utilized identical protocols and included eight insomniac patients. Sleep laboratory measurements in a limited number of patients are derived from all-night electro-encephalographic, electro-oculographic and electromyographic tracings. Unlike traditional methods of evaluation, they are quantitative, reproducible and projectable to large numbers of subjects.

Results shown represent average values in all subjects for the three consecutive nights of placebo administration prior to Dalmane therapy and the seven consecutive nights on Dalmane 30 mg.

Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

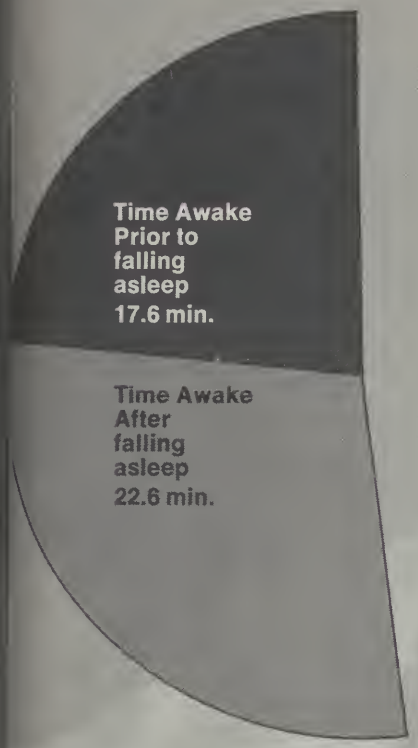
Before Dalmane (flurazepam HCl)



Measurements of sleep in the sleep laboratory are obtained with electroencephalographic, electro-oculographic and electromyographic recordings.

nd slept through the night

)n
)almane
flurazepam HCl)



e sleep laboratory measurements in cited studies

eter	Before Dalmane	On Dalmane
equired to fall asleep	33.6 min.	17.6 min.
ime after onset of sleep	48.7 min.	22.6 min.
r of wakeful periods after t of sleep	12.2	8.4
leep time	420.0 min.	447.5 min.
leep percent	88.6	94.5

nical effectiveness as
ven in the sleep laboratory

Dalmane®
urazepam HCl)

30-mg capsule h.s.—usual adult dosage.
15-mg capsule h.s.—initial dosage for rly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Nutley, New Jersey 07110

PENNSYLVANIA MEDICINE

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Journal of the Pennsylvania Medical Society

NOVEMBER 1971 VOLUME 74, NUMBER 11

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Short-acting diuretics may create abrupt, inconvenient waves of diuresis.
Long-acting Hygroton offers a gentle flow rather than abrupt diuresis.
It's smooth acting.
In edema and hypertension.

You know diuretics medically.

Hygroton® chlorthalidone USP

Makes water, not waves.

ectrolyte imbalance may occur when using diuretics. Hygroton is contraindicated in severe renal or hepatic diseases and, of
irse, if it causes hypersensitivity. Carefully supervise those who may be receiving other antihypertensives.

'groton® chlorthalidone USP *Indications:* Hypertension and many types of edema involving retention of salt and water. *Contraindications:* persensitivity and most cases of severe renal or hepatic diseases. *Warnings:* With the administration of enteric-coated potassium supplements, which ould be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and foration) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium pplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant women and rsing mothers since the drug crosses the placental barrier and appears in cord blood and since thiazides appear in breast milk. The drug may result fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of ildbearing age, balance benefits of drug against possible hazards to fetus. *Precautions:* Antihypertensive therapy with this drug should always be tiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. educe dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic termination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte balance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and tassium supplements given, provided the patient does not have marked oliguria. Take special care in cirrhosis or severe ischemic heart disease and in tients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. *Adverse Reactions:* Nausea, gastric irritation, vomiting, orexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic potension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, rombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and ncreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of mpounds include: jaundice, xanthopsia, paresthesia, and photosensitization. *Average Dosage:* 50 or 100 mg. with breakfast daily or 100 mg. every other y. *How Supplied:* White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000. (B)46-230-G *For full details, please the complete prescribing information.*

EIGY Pharmaceuticals, Division of CIBA-GEIGY Corporation, Ardsley, New York 10502

HY-7764-9

An epidemic that's striking home...

gonorrhea

There were more than 16,000 reported cases of gonorrhea in the Keystone State last year... almost 75 percent of them in Philadelphia alone

JA71-1692 © 1971 The Upjohn Company

In Pennsylvania... and everywhere else... a new alternative

NEW Trobicin®

SPECTINOMYCIN DIHYDROCHLORIDE, PENTAHYDRATE, UPJOHN

single-dose treatment for intramuscular use only

a chemically distinct antibiotic indicated specifically for treatment of acute gonorrhea:
in the male–acute urethritis and proctitis
in the female–acute cervicitis and proctitis
when due to susceptible strains of *N. gonorrhoeae*

High cure rate:* 96% of 571 males, 95% of 294 females (Dosages, sites of infection, and criteria for diagnosis and cure are defined on page 3 of advertisement).

Assurance of a single-dose, physician-controlled treatment schedule

No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed

Active against most strains of Neisseria gonorrhoeae *in vitro* (M.I.C. 7.5-20 mcg/ml)

A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing).

*Data compiled from reports of 14 investigators.

NOTE: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

For full prescribing information, including contraindications, warnings and precautions, please see last page of this advertisement.

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

Trobicin and the gonorrhea challenge

An accelerating epidemic— a decelerating susceptibility to penicillin

Gonorrhea is now the most prevalent reported communicable disease in the nation. The estimated number of new cases of gonorrhea in the United States exceeded two million for the first time in 1970. To compound the problems, strains of *N. gonorrhoeae* increasingly resistant to penicillin and other antibiotics are appearing throughout the country. Schedules of treatment which were effective only a few years ago now result in a significant percentage of treatment failure. *In vitro* studies have demonstrated that resistance of *N. gonorrhoeae* may also develop to Trobicin.

Thus, while aqueous Procaine Penicillin G remains the drug of choice for the majority of patients, the need for a non-penicillin, intramuscular antibiotic for acute gonorrhea in the male and female is abundantly clear. Such an antibiotic should be effective following a single intramuscular injection —and it should not demonstrate cross-resistance with penicillin

Trobicin—a new alternative specifically for the treatment of acute gonorrhea

Trobicin is indicated in the treatment of acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

High cure rates: 96% of 571 males, 95% of 294 females

No allergic reactions occurred in patients with an alleged history of penicillin hypersensitivity when treated with Trobicin, although penicillin antibody studies were not performed.

Chemically distinct

Trobicin is structurally not related to any other antibiotic commonly used to treat gonorrhea.

Intramuscular injections should be made deep into the upper outer quadrant of the gluteal muscle.

Adult male: Single 2 gram dose I.M. in acute gonorrheal urethritis. Single 4 gram dose I.M. (should be divided between two gluteal injection sites) in gonorrheal proctitis and in patients being re-treated after failure of previous antibiotic therapy. In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams intramuscularly is preferred.

Adult female: Single 4 gram dose I.M. (should be divided between two gluteal injection sites) in acute gonorrheal cervicitis and proctitis.

Safety for use in pregnancy has not been established, nor is safety for use in infants and children.

Clinical Results with Single-Dose Treatment, Intramuscularly* (Data compiled from reports of 14 investigators**)

	Dosage	Number of Patients	Number Cured	Percent Cured
Adult Males: Gonorrheal urethritis	**2 grams** **4 grams**	**475** **96**	**457** **93**	**96%** **97%**
Adult Females: Gonorrheal cervicitis	**4 grams**	**294**	**280**	**95%**

Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin medium in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included in the table above.

The following reactions were observed during the single dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

*4-grom doses were injected in two gluteol sites.

**Medicol Research Files, The Upjohn Company

a chemically distinct antibiotic indicated specifically for treatment of acute gonorrheal urethritis and proctitis in males and cervicitis and proctitis in females when due to susceptible strains of *N. gonorrhoeae*

new Trobicin®

STERILE SPECTINOMYCIN DIHYDROCHLORIDE PENTAHYDRATE, UPJOHN

single-dose treatment for intramuscular use only

erile Trobicin®
)ectinomycin dihydrochloride penta-
drate)—For Intramuscular injection:
gm vials containing 5 ml when reconsti-
ed with diluent. 4 gm vials containing
ml when reconstituted with diluent.

aminocyclitol antibiotic active *in vitro*
gainst most strains of *Neisseria gonor-*
oeae (MIC 7.5 to 20 mcg/ml). Defini-
e *in vitro* studies have shown no cross
sistance of *N. gonorrhoeae* between
obicin and penicillin.

dications: Acute gonorrheal urethri-
and proctitis in the male and acute
norrheal cervicitis and proctitis in the
male when due to susceptible strains
N. gonorrhoeae.

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atients previously found hypersensitive
Trobicin. Not indicated for the treat-
ent of syphilis.

arnings: Antibiotics used to treat gon-
rhea may mask or delay the symp-
ms of incubating syphilis. Patients
ould be carefully examined and
onthly serological follow-up for at least
months should be instituted if the diag-
sis of syphilis is suspected.

afety for use in infants, children and
egnant women has not been estab-
hed.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.

Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female— single 4 gram dose (10 ml) intramuscularly.

How supplied: *Vials, 2 and 4 grams —with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.

Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

For additional product information, see your Upjohn representative or consult the package insert.

MED-B-1-S (LWB)

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

IT'S NO SECRET...
that the Pennsylvania Medical Society's professional liability insurance program is off to a flying start...

with YOU aboard, its success will be assured!

The Pennsylvania Medical Society is gratified and encouraged by the extraordinary success to date of the Society-sponsored Professional Liability Insurance Program which went into effect June 1, 1971. The unfavorable insurance market conditions which prompted the Society's sponsorship of such a program, including arbitrary cancellations, non-renewals or refusals to write newly licensed physicians, still exist. Under the circumstances, it is still in the best long-term interests of *all* PMS members to transfer their individual malpractice insurance coverage as promptly as possible.

The PMS Program is completely "doctor-oriented," having been designed to provide *long-term* coverage and adequate limits at the best possible cost, in addition to giving the Society, on behalf of its members, an opportunity to participate in all important policy-making, administration and loss prevention aspects vital to the Program's success.

The program is being underwritten by the Argonaut Insurance Company, a well established, "A+AAAA" rated casualty insurance carrier with assets in excess of $180,000,000 and considerable experience in the medical liability field. The exclusive, full-time administrator of the program is Parker & Co. Inc. of Pennsylvania, one of the country's leading insurance brokerage firms.

In review, the major points of the program are:

1. The Pennsylvania Medical Society has entered into an agreement with the Argonaut Insurance Company to administer the program through Parker & Co., Inc. of Pennsylvania.
2. The Argonaut Insurance Company will be bound to make this program available for a *minimum of five years. No* other carrier has offered such an agreement.
3. The Society participates through a Professional Liability Insurance Commission consisting of twelve members. The Commission will be the ultimate authority in appeals stemming from disputes between member insureds and will work in close conjunction with the local district committees.
4. No member's application will be declined except by the *joint decision* of the PMS Commission and the Argonaut Insurance Company.
5. Full liability coverage of $100,000 for each claim with an annual aggregate limit of $300,000 with excess limits up to $1,000,000 available. Coverage *is* available for interns, residents and physicians' and surgeons' assistants.
6. Rates are competitive with other major writers of professional liability insurance in Pennsylvania.
7. There is no requirement that a member purchase ancillary insurance coverages (homeowners, auto, etc.) in order to participate.

This program offers PMS members a unique opportunity to stabilize their professional liability insurance coverage on a long term basis. However a broad based, high degree of membership involvement is essential to make this program a success. Please fill out the coupon indicating your interest in participating in the PMS endorsed program when your present coverage expires.

Argonaut Insurance Companies

Mail to:
Parker & Co., Inc. of Pennsylvania
1616 Walnut Street, Philadelphia, Pennsylvania 19103
Attention: Mr. A. John Smither, Vice President

Name _____

Office Address _____

Telephone No. _____

Medical Specialty _____

Date your professional liability insurance expires _____

Present Carrier _____

I am interested in participating in the PMS Professional Liability Insurance Program. Please send me an application. ☐

An insurance program sponsored and supported by the PMS.

PMS DELEGATES TO AMA PLAN FOR NEW ORLEANS Pennsylvania's delegation to the AMA Clinical Convention in New Orleans (see list of delegates and alternates elected on page 11 in this issue) will be minus three veteran delegates who have retired. They are Thomas W. McCreary, Sr., M.D., Rochester; Samuel B. Hadden, M.D., Philadelphia; and Wendell B. Gordon, M.D., Pittsburgh. Drs. Park M. Horton, PMS president-elect; William A. Limberger, PMS immediate past president; and William Y. Rial, speaker of the PMS House of Delegates, are serving on various reference committees of the AMA House of Delegates.

SCIENTIFIC ASSEMBLY NOVEMBER FEATURE Over 1,000 physicians and allied professionals are expected to attend the 1971 PMS Scientific Assembly November 8-11 at the Host Farm Motel, Lancaster. Four of the Commonwealth's medical schools assisted the Council on Education and Science in preparing the sessions, as did the Pennsylvania Nurses Association in preparing the seminars for nurses and other allied professionals. Twenty-three specialty programs have been prepared. General theme for the assembly is "Emergency Medicine."

PHS SAYS SMALLPOX VACCINATION NOT NEEDED The U.S. Public Health Service has announced its recommendation that routine smallpox vaccination is no longer indicated in the United States. The decision was based on the success of the efforts of the World Health Organization to eradicate smallpox throughout the world. PHS further recommended that states change compulsory laws regarding vaccines and that physicians and health agencies intensify efforts to report adverse reactions to vaccinations for smallpox and to observe the following contraindications to smallpox immunization: Eczema and other forms of chronic dermatitis in the individual or in a household contact, pregnancy, and altered immune states from disease or therapy.

TV CLINIC AT ACS CONGRESS The Clinical Congress of the American College of Surgeons conducted a four-day surgery clinic via closed circuit television and two-way communications from the operating rooms of Thomas Jefferson University Hospital, Philadelphia, to Convention Hall, Atlantic City. The program, which demonstrated surgery ranging from open heart and cancer surgery to cosmetic plastic surgical reconstruction, was directed by Gordon F. Schwartz, M.D., director of the surgical education program at Jefferson Medical College.

DRUG ABUSE TRAINING ANNOUNCED The Drug Education and Training Center at Eastern Pennsylvania Psychiatric Institute (EPPI) has announced the initiation of a two-year program of education on the subject for physicians and others

working to solve the problem. Initial sessions, scheduled for December 13-17, have been planned by EPPI and Eagleville Rehabilitation Center. For further information contact Program Director Uri Rueveni Ph.D. at EPPI.

HOSPITAL ADDITION ATTACKED State Insurance Commissioner Herbert S Denenberg has ordered Capitol Blue Cro; not to pay any costs related to a proposed 165-bed addition to Holy Spirit Hospital in Camp Hill on the grounds that a state plan shows a need for only twenty-eight additional beds in the area the hospital serves.

NEW YORK ABORTIONS COUNTED The New York State Health Department h; reported an estimated total of 215,453 abortions performed there in the first year of the liberalized law, with 54 percent of the operations performed on out-of-state residents Canada and the five states adjacent to New York accounted for nearly half of all of the out-of-state abortions.

HEALTH INSURANCE CONTROL ASKED The Nixon Administration is asking the Congress to authorize federal regulation of private health insurance companies as part of its plans to expand health insurance coverage by requiring employers to provide such coverage and pay most of the premiums.

FDA CAUTIONS ON TB DRUG USE The FDA has issued precautions agains the use of isoniazid, a tuberculosis cure and preventive, which was given last year to 2,321 U.S. Capitol workers, two of whom subsequently died. The FDA rated the drug an excellent cure and preventive for TB but said patients should be carefully screened for susceptibility to side effects, particularly liver damage.

FOOTBALL INJURY STUDY ORDERED A one-year study of high school football injuries is being conducted in the Johnstown area by the Pennsylvania Department of Health. The project was urged by Sidney Goldblatt, M.D., director of medical education at Conemaugh Valley Hospital and a member of the PMS Council on Education and Science. The department expects to extend the study to other areas if the findings warrant it, and ultimately may make recommendations for revision of playing rules, modifications in training programs, and more functional equipment.

HEW SECRETARY PROPOSES INSURANCE REGULATIONS HEW Secretary Elliot L. Richardson has approved proposed regulations enabling insurance carriers who provide coverage through the Federal Employees Health Benefits Program to issue contracts for prepaid group medical services to any individual in any state. Authority for issuance of the regulations which were published in the Federal Register and are now subject to comment before final adoption is contained in Public Law 91-515. The proposed regulations are expected to stimulate the formation and development of group practices throughout the country.

New PMS officers take helm

Park M. Horton, M.D., New Mil-rd, was elected president-elect of the nnsylvania Medical Society at the nnual Session of the House of Dele-tes in Pittsburgh last month.

The former trustee and councilor om the Twelfth District served as airman of the Board of Trustees for o years prior to his election. In-alled as president was George P. osemond, M.D., Philadelphia. The oard of Trustees elected David S. asland, M.D., Carlisle, as its airman. Formerly vice-chairman of e Board, Dr. Masland also served as airman of the Finance Committee.

Four vice-presidents were elected. rs. Charles K. Rose, Allentown, first ce-president; Charles A. Bikle, hambersburg, second vice-president; dward T. Lis, York, third vice-esident; and Carmela F. deRivas, Vayne, fourth vice-president.

Raymond C. Grandon, M.D., Har-sburg, was re-elected secretary. William Y. Rial M.D., of Swarthmore as re-elected speaker of the House of Delegates and the vice-speaker, John . Lovette, M.D., of Johnstown, also as re-elected.

Four positions on the Society's oard of Trustees were filled. Drs. eRoy A. Gehris of Reading, David J. eck, of Fairview, and William C. yan, of Somerset, were re-elected to ive-year terms, and Orlo G. McCoy, M.D., of Canton, was named for the ear remaining in the unexpired term f Dr. Horton.

Dr. Lewis T. Buckman of Wilkes-arre was re-elected to the Judicial ouncil.

Five delegates and five alternate del-gates to the American Medical Asso-iation were elected. The delegates are Drs. John B. Lovette of Johnstown, Malcolm W. Miller and Paul S. Friedman, of Philadelphia, Russell B. Roth, of Erie, and Matthew Marshall, Jr., of Pittsburgh. The alternates are Drs. Robert F. Beckley, of Lock Haven, William J. Kelly, of Pitts-burgh, Wilbur E. Flannery, of New Castle, John Helwig, Jr., of Philadel-phia and David S. Masland, of Carlisle.

The delegates elected five members of the committee to nominate AMA delegates. They are Drs. Fred C. Brady, of Pittsburgh, John B. Mont-gomery, of Philadelphia, Edgar W. Meiser, of Lancaster, Donald E. Harrop, of Phoenixville, and John Steigerwalt, of Rosemont.

The delegates also elected district censors. They are: Drs. James H. Allison, of Gettysburg; Robert A. Schein, of Pittsburgh; Arthur R. Wilson of Dayton; Herman Bush of Beaver; William E. Palin, of Bedford;

DR. HORTON

Eugene Mendelsohn of Reading; John W. Hurst, of Altoona; Willis W. Red-ding, of Towanda; Stanley F. Peters, of Plumsteadville; Robert C. McCorry of Butler; Warren F. White of Johnstown; H. Richard Ishler, of State College.

Drs. Grant W. Bamberger, of Honeybrook; Theodore R. Koenig, of Knox; Dr. Fred Pease, of Clearfield; George J. Treires, of Lock Haven; James F. Youngkin, of Berwick; David D. Kirkpatrick, Jr., of Meadville; Hans S. Roe, of Carlisle; Nathan Sussman, of Harrisburg; Richard H. Flandreau, of Media; James L. Hackett, Sr., of Empo-rium; Robert L. Loeb, of Erie; Harold L. Wilt, of Brownsville; Albert W. Freeman, of Shippensburg; William W. Bartholomew, of Waynesburg; Thomas Mainzer, of Huntingdon; Harold L. Edison, of Indiana.

Drs. Franklin S. Bizousky, of Punx-sutawney; Joseph J. O'Brien, of Scranton; Charles H. Kurtz, of Lancaster; Gerald H. Weiner, of New Castle; C. Ray Bell, Jr., of Lebanon; Frederick R. Bausch, Jr., of Allen-town; Dr. Donald F. Closterman of Kingston; Dr. Wilfred W. Wilcox, of Montoursville; Dr. Ralph E. Hocken-berry, of Kane; Dr. Robert W. Sass, of Sharon.

Drs. John R. Hunter, Jr., of Lewis-town; Claus G. Jordan, of East Stroudsburg; Rudolph K. Glocker, of Pottstown, Isaac L. Messmore, of Danville; Walter J. Filipek, of Heller-town; Nicholas Spock, of Shamokin; Frank A. Belmont, of New Bloom-field; Charles M. Thompson, of Philadelphia; Herman C. Mosch, of Coudersport; Joseph T. Marconis, of Pottsville; Alexander Solosko of Myersdale; Raymond C. Davis of Susquehanna; Ivan T. Brechbill of Wellsboro; John S. Purnell, Sr., of Mifflinburg; James Farr, Lehighton.

Also, Drs. Frank Esparraguera, of Oil City; Donald J. Furman, of Warren; Herbert J. Levin, of Donora; Howard R. Patton, of Honesdale; Leslie S. Pierce, of Greensburg; John S. Rinehimer, Jr., of Tunkhannock and William C. Langston, of York.

Dr. Rowland elected AAFP board member

George A. Rowland, M.D., Millville family physician and PMS Fourth Dis-trict Trustee and Councilor, was elected to a three-year term as a member of the Board of Directors of the American Academy of Family Physicians at its meeting last month in Miami Beach.

J. Jerome Wildgen, M.D., Kalispell, Mont., became president-elect, and James L. Grobe, M.D., Phoenix, Ariz., was elected president-elect of the 31,000-member association, formerly called the American Academy of Gen-eral Practice.

Dues increase ordered by delegates

The PMS House of Delegates authorized the first increase in Society dues since 1964 at its Annual Session in Pittsburgh last month.

The House approved without dissent a $25 increase to bring the annual assessment to $100. The step was said to be necessary because of the inroads inflation has made on State Society purchasing power since the last dues increase.

With the opening session of the House, the then chairman of the Finance Committee, David S. Masland, M.D., said that the Society's 1972 budget carried a deficit of $121,569 on the basis of the $75 annual assessment. He noted that other comparable medical societies have increased their dues an average of 41% since 1965 and that the annual assessment in those states now approximates $105 per member. He said there are 16 state societies with dues in excess of $100.

The reference committee which considered Dr. Masland's statement said there was "little testimony either for or against a dues increase" at its hearing. The reference committee, however, supported the concept of a reasonable dues increase to offset the effects of inflation and the added costs of new programs approved by the House of Delegates. The reference committee did not arrive at a consensus on the dollar amount of the increase needed but it did suggest that the Finance Committee increase its scrutiny of any unnecessary or inappropriately funded programs and "eliminate these from budgetary support so as to keep the increase in dues to a minimal amount."

As the final item of House business prior to adjournment, Dr. Masland spoke again to say that House actions and the budgetary deficit made it necessary for him to recommend that the dues be increased by $25 to $100. Such a motion was made, seconded and approved without dissent.

The dues increase is subject to any regulations that may be developed to implement Phase Two of the federal government's wage-price freeze but initial exploration of the qu tion indicated that the federal board responsible would all such a dues hike.

Other parts of Dr. Masland's statement noted that t dues increase has been avoided since 1964 because of t prudent expenditure of funds by councils and committees.

He said: "During the past seven years we have experienc a 32.8% rate of inflation. Nearly a third of the Societ purchasing power has eroded in the process. During the sar time, the Society has increased its activities and initiated pr grams designed to assure quality medical care as well as o timum utilization and distribution of medical services. T Society also constructed a new headquarters building duri this period without the need for a special building asse ment, a dues increase or a large mortgage. I think you w agree that the membership received an excellent return c that last dues increase."

He noted that the House would give consideration to tl implementation of the Pennsylvania Medical Care Found tion which he described as "the most significant program tl Society has initiated in a decade." He added: "Obviously, v cannot afford to curtail such programs as this which are vit to the membership's interest and to the public good..."

The House approved the intent of a recommendation fro PMS President Rosemond calling on the Board of Truste and its Finance Committee to conduct a total re-evaluatic of dollar priorities. The approved reference committee repo dealing with this subject said that it "believes that this is of u most importance." The reference committee urged "th Board of Trustees and the Finance Committee to continue t give careful consideration to priorities, especially in view c increasing costs and the probability of a dues increase. Th reference committee believes that any ineffective prograr should be eliminated."

Physician-Short areas subject for House actions

The House of Delegates modified and approved a resolution directed at alleviating the physician shortage in rural areas of the state. It urged the State Society to "communicate with the appropriate authorities in Pennsylvania medical schools, emphasizing the urgent need for rural physicians, and encourage those schools to select more applicants, otherwise qualified, who are residents in the rural areas in the hope that they may return to such areas to provide medical service."

Joint Statement Approved

The House of Delegates and the Board of Trustees approved a joint statement of the deans of the medical schools and PMS calling attention to the fact that demands for improved health care delivery and increased manpower occur at a time when schools are having serious financial problems.

It includes a joint commitment by the medical schools and the State Society to continue efforts for greater financial support of the medical schools, expansion of loan programs to medical students, the use of the physician placement service to contribute to better distribution, and the support of federal mechanism to substitute physician service in areas of need as an alternate to military service.

The statement pledges to improve "access to health care professionals in all areas of the state, including remote rural districts and center cities," and to "plan curricula that will direct students into primary medicine and specialties where the current need exists and graduate them in the shortest possible time consistent with quality."

The suggestion of a governmen sponsored draft in order to improve di tribution of medical care in the stat produced varied reaction.

Dr. Rosemond commented, "Ther must be a better way than government-sponsored draft." Th approved reference committee repo stated, "The committee doubts tha manpower for rural health care shoul be provided as part of the military draf It seems obvious that rural deferment will only result in an increase in th total number of physicians drafted."

However, the House approved th consideration by PMS of all alterna tives, including a possible draft Another proposal was for an explora tion of funding for establishing one o several mobile medical care and labora tory service delivery units in rura areas.

Amphetamine use curb prescribed by doctors

Action to reduce the use of amphetamines by urging physicians throughout the Commonwealth to limit the prescribing of the drug only to certain clinical conditions such as narcolepsy and hyperkinesis was taken by the PMS House of Delegates in Pittsburgh last month. The resolution specifically urged physicians not to prescribe amphetamines for appetite control.

The House noted that the resolution introduced by the Allegheny County Medical Society was in keeping with a position statement adopted by the Board of Trustees on the recommendation of the Council on Education and Science.

In passing the resolution and endorsing the Board's position, the House cited the voluntary restriction "as a positive contribution that the medical profession can make toward the curbing of drug abuse," by decreasing the availability of the drug and the abuse of it.

The resolved portion of the resolution reads:

"Resolved that Pennsylvania physicians be urged by action of the House of Delegates to refrain from prescribing amphetamines except in special clinical conditions such as narcolepsy or hyperkinesis, and be it further resolved that physicians be urged not to prescribe amphetamines for purpose of appetite control, and be it further resolved that the Pennsylvania Pharmaceutical Association be informed of this resolution and be urged to cooperate with the medical profession in these efforts, and be it further resolved that information regarding these problems and solutions for combating drug abuse be disseminated through official publications of the state and county medical societies and to the public as soon as possible."

AMA Executive V.P. To speak at York

Ernest B. Howard, M.D., executive vice-president of the American Medical Association, has agreed to be the speaker at a special meeting of the York County Medical Society on Thursday evening, Dec. 9, 1971.

York plans to invite members of nearby counties to the session which is one of a series the county society officers have planned to revitalize membership awareness of and commitment to organized medicine.

Dr. Howard will speak on the subject, "What Does the AMA Do For You?" and plans an ample question and answer period following his speech.

Education standards set by delegates

New educational standards which will require active and senior active members of the State Society to qualify for the American Medical Association's Physician Recognition Award in order to retain membership in the State Society were adopted by the House of Delegates, which approved changes in the Constitution and Bylaws calling for continuing education.

The Recognition Award requires 150 hours of approved learning in each three-year period beginning July 1, 1972. The same criteria will apply to each three-year period thereafter. Each new member will have three years in which to meet the requirements. The Board of Trustees was given power to waive the requirement for those temporarily serving in the armed forces or ill.

Qualifying education ranges from continuing medical education courses to teaching medical students, the publication of papers, medical research, hospital and medical society scientific meetings, and scientific exhibits.

A future issue of PENNSYLVANIA MEDICINE will carry details.

Educational Institute Approved

The House endorsed the incorporation and organization of the Pennsylvania Medical Continuing Education Institute to coordinate postgraduate courses in the state.

Hospital Consultation Service Commended

The House commended the Council on Education for its work to develop medical education consultation services for community hospitals, and for establishing lists of regional and statewide faculties and lists of teachers as a resource for teaching programs in all areas of the state.

AT THE PLATFORM at the final meeting of the House of Delegates are these leaders, past and present, of the Society. Shown, left to right, are President-Elect Park M. Horton, M.D., Past President William A. Limberger, M.D., President George P. Rosemond, M.D., and William A. Barrett, M.D., who served as president two years ago.

House action updates Society structure

The House of Delegates ordered three changes in Society structure at the 1971 Annual Session.

It changed the name of the Advisory Committee to the Executive Director to Executive Committee of the Board. The new name describes more accurately the duties of the committee as ordered by the Board of Trustees, which is empowered to delegate limited powers to the committee between sessions of the Board. At the same time the House rejected a resolution calling for monthly Board meetings, noting that the time devoted by trustees to Society activities "is already considerable," and that use of the Executive Committee is a "more efficient way of doing business."

Objectives Committee Changed

The composition and number of members of the Committee on Objectives has been changed. Instead of fifteen members appointed by the president, the committee will consist of seven members, four appointed by the speaker of the House of Delegates, and three appointed by the president. The House directed that of those appointed by the speaker, one shall be either a SAMA member, an intern, or a resident. The committee will select its own chairman and vice-chairman and continue to prepare an annual report to the House of Delegates.

Defense Fund Goal Changed

With the advent of the PMS-endorsed malpractice insurance program, the House ordered that the Medical Defense Fund be abolished and that the Board of Trustees be granted authority to support financially any medical-legal causes that would significantly affect the Society or a large number of members. The original purpose of the fund was to provide legal assistance for those who did not have or could not get medical liability insurance.

House moves to seek more active members

Participation in medical society activities by all physicians caused the 1971 House of Delegates to take several actions.

In recognition of the importance of the widest possible physician representation in the State Society, the House directed the Trustees and Councilors to contact each county society at least annually requesting a progress report on membership recruitment.

The reference committee suggested that county medical societies could effectively increase their membership by amending bylaws to make interns and residents eligible. Noting that a survey of non-members revealed that many had never been asked to become members, the committee report urged members to contact non-member physicians in their communities.

The House further approved the concept of membership for third and fourth year medical students and referred the matter to the Committee on Constitution and Bylaws for study.

Attention was focused on the problem of establishing and maintaining contact with medical students interns, and residents in an effort to involve them in organized medicine on the county and state level. Suggested methods of establishing closer contact included:

Encouraging all types of personal relationships between individual physicians and individual students, interns and residents;

Re-emphasizing the Society's continued support of the MECO and Appalachia (preceptor-type) programs

Holding informal gatherings with county society involvement at which members and students would feel free to discuss common interests and problems."

Blue Cross/Shield subject of actions

A number of items concerning Blue Cross and Blue Shield were on the agenda when the House of Delegates met last month in Pittsburgh.

The House recognized that the Council on Medical Service "has been diligent in carrying out liaison responsibilities with Blue Shield and filed as information a Pennsylvania Blue Shield report to the House, noting its growth, and urging that it continue to improve the administration of its programs.

Oppose "Plan C"

The House supported a recommendation of the Council on Medical Service that the State Society oppose Blue Shield's proposal to establish a new "Plan C" fee schedule, and instead to continue its efforts to improve the "Plan B" fee schedule, with the understanding that it will necessitate raising the income level for "Plan B" service benefits. The House agreed that a new fee schedule "would not be in the best interests of the public or profession and in the long term would have an adverse effect on the prevailing fee program."

The House reiterated its support of the prevailing fee concept but noted that there "are still numerous problems and considerable misunderstanding relative to the development of doctor profiles and their use in administration of the prevailing fee concept."

Support Liaison

Liaison with Blue Cross programs was supported by the House of Delegates, which said it was impressed with the activities of the PMS-Blue Cross Regional Steering Committee in Western Pennsylvania. It urged the Council on Medical Service to continue its efforts to establish such committees to the other four Blue Cross service areas in the state.

Pre-Admission Testing Urged

The House supported a recommendation that Blue Cross be urged to expand pre-admission testing with Blue Shield as a participant so that pre-admission studies could be conducted in an outpatient facility or a physician's office.

Medical Assistance Program scrutinized at session

"The extraordinary dissatisfaction of ysicians" with the state's Medical Astance Program was emphasized as e PMS House of Delegates took a ries of actions expressing that dissatfaction and seeking solutions to some the problems.

One resolution even urged physians not to participate in the Medical ssistance Program unless the Departent of Public Welfare makes changes thin six months. The House of Deletes amended that resolution to elimite the first resolve concerning nonrticipation as "not representing a actical solution for improving the edical Assistance Program at this me."

As amended the adopted resolution oints up physician activity to develop id implement effective health care ost control mechanisms and said that espite this, "the Pennsylvania Departent of Public Welfare has promulated cumbersome, ineffective, useless, id unworkable regulations for... the Medical Assistance Programs." It furher notes that the Department has not emonstrated "any sincere interest in iscussing reasonable solutions" and hat the Medical Assistance Program egulations do not serve the best interests of disadvantaged citizens and are ven discriminatory. The resolution rges physicians to render the best servce to all patients, urges medical staffs o expand utilization activities to nclude all patients on a uniform basis, lirects the State Society to continue to levelop new and better utilization eview techniques and mandated disribution of the resolution to all nembers of the State Society, county nedical societies and hospital medical taffs with a request for an indication of heir support.

Welfare Secretary Responds

The House noted that the Secretary of Public Welfare had responded to a etter from Dr. Limberger recommending removal of the requirement or a 72-hour review of all admissions and the omission of the check list, the establishment of a pilot program of payment to evaluate the effectiveness of paying usual and customary fees under the Medical Assistance Program, and the organization of a representative committee to review and develop workable medical assistance regulations.

Rescind Review Clause

The House adopted a resolution which directed the State Society to "strongly recommend that the Pennsylvania Department of Welfare strike the 72-hour review clause from its utilization review regulations." The adopted resolution pointed out the discriminatory nature of the 72-hour regulation. It also adopted a resolution which reaffirmed the State Society's position that the usual and customary fee concept "is the only proper basis for continued highest quality care for all people..." and it directed the State Society to urge the Commonwealth to adopt the usual and customary fee basis for medical assistance patients "as rapidly as is financially possible."

Patient Discharge Summary

It adopted still another resolution which noted that a new welfare regulation requires that a copy of the patient discharge summary sheet on all in-patient cases now must be attached to every medical assistance invoice submitted for payment and that this imposes extra work and hardship on hospitals and delays payments. The resolution resolves that the State Society urge the Welfare Department to rescind the directive or modify it to remove "this undue delay in payments to hospitals." In commenting on this resolution, the approved reference committee report agreed that pertinent information from hospital records should be provided to third parties for legitimate reasons but it noted that "it is not in the patient's best interest to transmit, in its entirety, the discharge summary or other information from the hospital record." It said such indiscriminate dissemination of private information would only serve to violate the patient's right to privacy and the patient/doctor relationship. The resolution was adopted without dissent.

Improved Program Asked

In its general comments about the Welfare Department situation, the approved reference committee report said:

"The reference committee believes that the Pennsylvania Medical Society should pursue with vigor the objectives established by this House of Delegates relative to improvement of the Medical Assistance Program. We recognize that many of the problems related to the Medical Assistance Program will not be resolved until more favorable fiscal action is taken by the Pennsylvania Legislature... We recommend that the appropriate body of the Pennsylvania Medical Society bring the problems of the Medical Assistance Program to the immediate attention of the leadership of the Pennsylvania Legislature."

The House expressed its pleasure that the Council on Medical Service had been given an opportunity by Public Welfare to review and comment on proposed changes in rules and regulations for licensing hospitals.

Board to study health quackery committee

The 1971 House of Delegates has directed the Board of Trustees to consider creating an organization of physicians and laymen which would consider a public education program on what constitutes health quackery.

The resolution was a substitute for one calling on the State Society to establish a committee on quackery, and to endorse and publicize the Lehigh Valley Committee on Health Fraud and its program.

The adopted resolution suggested that if such an organization is formed it should explore the value of the Lehigh Valley program "if such an organization deems it appropriate."

The House also directed the Council on Governmental Relations to continue its efforts to achieve legislation which would establish a cutoff date for further chiropractic licensing.

House lauds PMS malpractice program

The PMS Professional Liability Insurance Program, which became operational June 1, 1971, was praised by the 1971 House of Delegates as "one of the most progressive, comprehensive insurance programs ever offered to a medical group." It commended the Council on Medical Service for its initiative in establishing the plan.

The program is administered by Parker and Co. of Pennsylvania and underwritten by Argonaut Insurance Co.

The House praised the Council "for its outstanding efforts in resolving the mounting malpractice insurance problems confronting our members." The program does this by providing the State Society with authority to make final decisions in underwriting questions, and offers freedom from renewal worries for at least five years.

The Board of Trustees has named th Society's legal counsel, Pepper, Ha milton and Scheetz, Philadelphia, a chief defense council for the liability in surance program.

County secretary dies

Robert E. Lynch, executive secretary of the Cambria County Medical Society, died suddenly in an automobile accident while returning from the Annual Session of the House of Delegates of the Pennsylvania Medical Society in Pittsburgh. His wife and two sons survive him.

Family practice exams scheduled for April

The American Board of Family Practice will give its next examination for certification in various centers throughout the United States over a two-day period on April 29-30, 1972. The deadline for receiving applications is February 1, 1972.

For further information contact: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

Polyclinic has service

Polyclinic Hospital, Harrisburg, ha announced the operation of a ne photo telecopier, the first in the are to transmit information to Hal nemann Medical College and Hospit in Philadelphia for speeding treatme programs for cancer patients.

According to Leonard C. Grif M.D., chief of the department radiology therapy at Polyclinic, info mation and a diagram of the lesion transmitted to Hahnemann, and radi tion treatment recommendations ca be retransmitted to the originating ho pital within an hour.

The service is part of the Region Medical Program and is approved b the National Science Council.

REFERENCE COMMITTEE members are shown here in session. In the picture to the right are, left to right, Dominick A. Cruciani, Jr., M.D., Ling G. Wong, M.D., and Malcolm W. Miller, M.D., of the Reference Committee on Education and Science. In the bottom photograph, the Reference Committee on Public Service is shown in action. From the left are Frank Belmont, M.D. Carol Maurer, M.D., Kenneth Miller, M.D., SAMA Delegate Margaret Mullins, and Charles K. Zug, III, M.D. Just above are, same order, Drs. Robert Davis, R. Robert Tyson, Vincent Ricciutti, and Bienvenido V. Simuangco— members of the Reference Committee on Constitution and Bylaws.

A JOHN SMITHER, vice-president of Parker and Co. of Pennsylvania, is shown above, left, presenting to Past President William A. Limberger, M.D. policy Number One under the new PMS malpractice insurance program. The presentation was made at Annual Session.

Annual Session Caught by Camera

EONARD E. EGERMAN, M.D., of ittsburgh, is shown below testifying behalf of a resolution authored by im on objectionable conditions in ursing homes before the Reference ommittee on Governmental Relaons.

BENJAMIN RUSH AWARD WINNERS received plaques at the state dinner for their efforts to alleviate health needs of others. Kenneth L. Cooper, M.D., chairman of the Council on Public Service, right, presented the individual Rush Award to Gustav Schukraft, of Fleetwood, center, and the group award to Owen W. Lininger, past president of the Greenville Lions Club, who accepted on behalf of the club.

THE PMS MEDICAL CARE FOUNDATION report was studied at a special Reference Committee hearing attended by most of the delegates. Shown below is part of the audience at the hearing. At right are members of the committee, left to right: Drs. Eugene W. Herron; Rex A. Pittenger; Chairman Ulysses E. Watson; Matthew Marshall, Jr., at the microphone testifying as chairman of the PMS Subcommittee on Medical Care Foundation; Kenneth R. Cooper; and Mr. Larry R. Fosselman, project director of the PMS Medical Care Appraisal Project.

THE WOMAN'S AUXILIARY of the Pennsylvania Medical Society, holding its forty-seventh annual business session in conjunction with the Annual Session of the PMS House of Delegates was privileged to have Mrs. Robert F. Beckley, president-elect of the AMA Woman's Auxiliary as the keynote speaker. Mrs. Beckley, shown above left, is from Lock Haven. In the center photo, Mrs. Leroy A. Gehris, past president, is shown passing the gavel to the newly installed president, Mrs. Ralph S. Blasiole. Shown at the far right is Mrs. Frank J. Corbett, speaker of the House of Delegates, who chaired the session. Delegates heard a report that the Northumberland County Auxiliary had received an award for the greatest per capita donation to the AMA-ERF; the Venango Auxiliary for the greatest donation to the PMS Education Fund; and the Schuylkill Auxiliary for the largest donation to the PMS Medical Benevolence Fund.

PAST PRESIDENTS and honorary members attending the Woman's Auxiliary Gavel Club Dinner included, seated left to right, Mrs. Alfred W. Crozier, Mrs. John A. Schneider, Mrs. Kermit L. Leitner, Mrs. Walter F. Donaldson, and Mrs. Jay G. Linn. Standing, left to right, Mrs. A. Wesley Hildreth, Mrs. Axel K. Olsen, Mrs. Leroy A. Gehris, Mrs. Malcolm W. Willer, Mrs. Lucian J. Fronduti, and Mrs. Manuel A. Bergnes.

AT THE ANNUAL STATE DINNER, Park M. Horton, M.D., then chairman of the Board of Trustees, is shown above, far left presenting the past president's plaque to William A. Limberger, M.D., immediate past president. In the photo on the right above, George A. Rosemond, M.D., left, is sworn in as the 122nd president of the Pennsylvania Medical Society by Dr. Horton who, the next day, was elected president-elect of the Society by acclamation.

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T_4 IS THE PREDICTABLE HORMONE BECAUSE IT LOVES PROTEIN.

SYNTHROID® (sodium levothyroxine) is pure synthetic T_4, the major circulating thyroid hormone. It is reliable to use because of its affinity for protein-binding sites in the blood. T_3 is more fickle. Sometimes it binds. Sometimes it doesn't. T_4 more *predictably* binds to protein.

Synthroid®
(sodium levothyroxine)

ALL THYROID-FUNCTION TESTS ARE USEFUL IN MONITORING SYNTHROID THERAPY

No calculations are needed, test interpretation is simple.

Any of the commonly used T_4 thyroid function tests (P.B.I., T_4 By Column, Murphy-Pattee, Free Thyroxine) are useful in monitoring patients on T_4 because they *all* measure T_4. Patients on SYNTHROID are thereby easy to monitor because their results will fall within predictable, elevated test ranges. Of course, clinical assessment is the best criterion of the thyroid status of the drug-treated patient.

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

TWO GOOD REASONS WHY THE ROAD TO NORMALIZED THYROID STATUS IS SO SMOOTH FOR THE SYNTHROID PATIENT

(1) The onset of action of T_4 is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of le concern because of this factor)[1] (2) since SYNTHROID contains or T_4, the potential for metabolic surges traceable to more potent iodides (T_3) is eliminated.

AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF THE PATIENT DURING THE BEGINNING OF THERAPY WILL ALERT THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

Side effects, when they do occur are related to excessive dosage. Caution should be exercised in administering the drug to patients with cardiovascular disease. Rea the accompanying prescribing information for additional data or write Flint Laboratories.

Choose the Smooth Road ...to thyroid replacement therapy

F TIENTS CAN BE S CCESSFULLY NAINTAINED ON A I?UG CONTAINING]IYROXINE ALONE.

T roxine (T_4) is, as you know, t major circulating hormone p duced by the thyroid gland. T s also produced, in smaller a ounts, and is active at the c ular level. For years it has been a orking hypothesis among e ocrinologists that T_4 is c verted by the body to T_3. In 1) this process, called " iodination," was demonstrated b Sterling and Braverman[2]. T loes convert to T_3, though the p cise quantities are still being s lied.

he conversion has been c ically demonstrated during the a inistration of T_4 to athyrotic p ents. Their thyroid status is n malized on SYNTHROID alone, y the presence of T_3 in these p ents has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[4] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

'HE FACTS ARE (LEAR AND HERE . OUR OFFER.

ICTS:
nthetic thyroid drugs are an provement over animal gland ducts. Patients, even athyrotic es, can be completely intained on SYNTHROID (T_4) ne. Thyroid function tests are sy to interpret since they are *dictably* elevated when the tient adheres to SYNTHROID. all synthetic thyroid drugs, NTHROID is the most nomical to the patient.

A

OFFER:
Free TAB-MINDER medication dispensers to start or convert all your hypothyroid patients to SYNTHROID. Free information to physicians on role of thyroid function tests in a new booklet titled: "Guideposts to Thyroid Therapy." Ask us.

Name

Address

City State Zip

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

FLINT LABORATORIES
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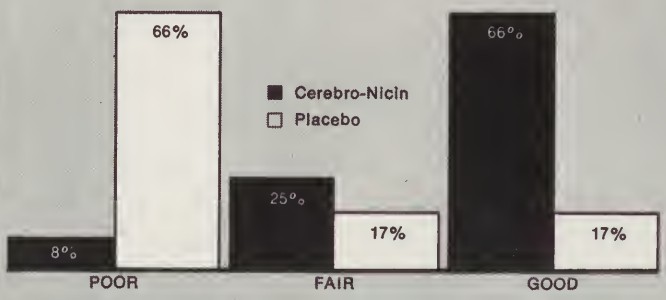
For the treatment of the aging patient

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
1-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir 8 oz. bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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2500 W. 6th St., Los Angeles, Calif. 90057
Write for Product Catalog

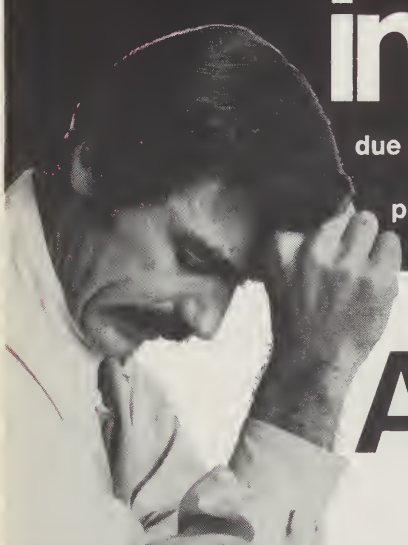
The treatment of

impotence

due to androgenic deficiency in the American male.
The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients—Double Blind St... T. Jakobovits
Fertility and Sterility, January 19...
Official Journal of the American Fertility Society



Android®

(thyroid-androgen) tablets

Double-Blind Study and Type of Patient:
100 patients suffering from impotence. ... the patients receiving the active medicat... (Android) a favourable response was se... in 78%. This compares with 40% ... placebo. Although psychotherapy is in... cated in patients suffering from functio... impotence the concomitant role of cher... therapy (Android) cannot be disputed.

Choice of 4 strengths:

Android

Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

REFER TO PDR

Android-HP

HIGH POTENCY

Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiac disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. Montesano, P., and Evangeliste, I. Methyltestosterone-thyroid treatment of male impotence. Clin Med 12:69, 1966. 2. Dublin, M. F. Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. Titeff, A. S. Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F. Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:1959. 5. Farris, E. J., and Colton, S. W. Effects of L-thyroxine and liothyronine on spermatog... J Urol 79:863, 1958. 6. Osol, A., and Farrar, G. E. United States Dispensatory (ed. 25). Lippincott, ... delphia, 1955, p. 1432. 7. Wershub, L. P. Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

Write for literature and samples: BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 907...

For Insomnia... one capsule for the rest of the night

NOLUDAR® 300

(methyprylon)

Before prescribing, please consult complete product information, a summary of which follows:
INDICATION: Relief of insomnia of varied etiology.
CONTRAINDICATIONS: Patients with known hypersensitivity to the drug.
WARNINGS: Caution patients about combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness, such as operating machinery or driving a motor vehicle shortly after ingesting the drug.
Physical and Psychological Dependence: Physical and psychological dependence rarely reported. If withdrawal symptoms do occur they may resemble those associated with withdrawal of barbiturates and should be treated in the same fashion. Use caution in administering to individuals known to be addiction-prone or those whose history suggests they may increase the dosage on their own initiative. Repeat prescriptions should be under adequate medical supervision.
Usage in Pregnancy: Weigh potential benefits in pregnancy, during lactation, or in women of childbearing age against possible hazards to mother and child.
PRECAUTIONS: If sleeplessness is pain-related, an analgesic should also be prescribed. Perform periodic blood counts if used repeatedly or over prolonged periods. Total daily intake should not exceed 400 mg, as greater amounts do not significantly increase hypnotic benefits.
ADVERSE REACTIONS: At recommended dosages, there have been rare occurrences of morning drowsiness, dizziness, mild to moderate gastric upset (including diarrhea, esophagitis, nausea and vomiting), headache, paradoxical excitation and skin rash. There have been a very few isolated reports of neutropenia and thrombocytopenia; however, the evidence does not establish that these reactions are related to the drug.

Each capsule contains 300 mg of methyprylon.

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

ALSO AVAILABLE FOR THE TREATMENT OF

impotence

due to androgenic deficiency in the American male.

Android® 5

MUQETS
BUCCAL Tabs

Methyltestosterone N.F.-5 mg.

Android® 10

Methyltestosterone N.F.-10 mg.

Android® 25

Methyltestosterone N.F. -25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en 3-one.

ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are seconlary to androgen deficiency 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastic breast carcinoma. If this occurs, the drug should be discontinued

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia

DOSAGE AND ADMINISTRATION: Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

Write for Literature and Samples

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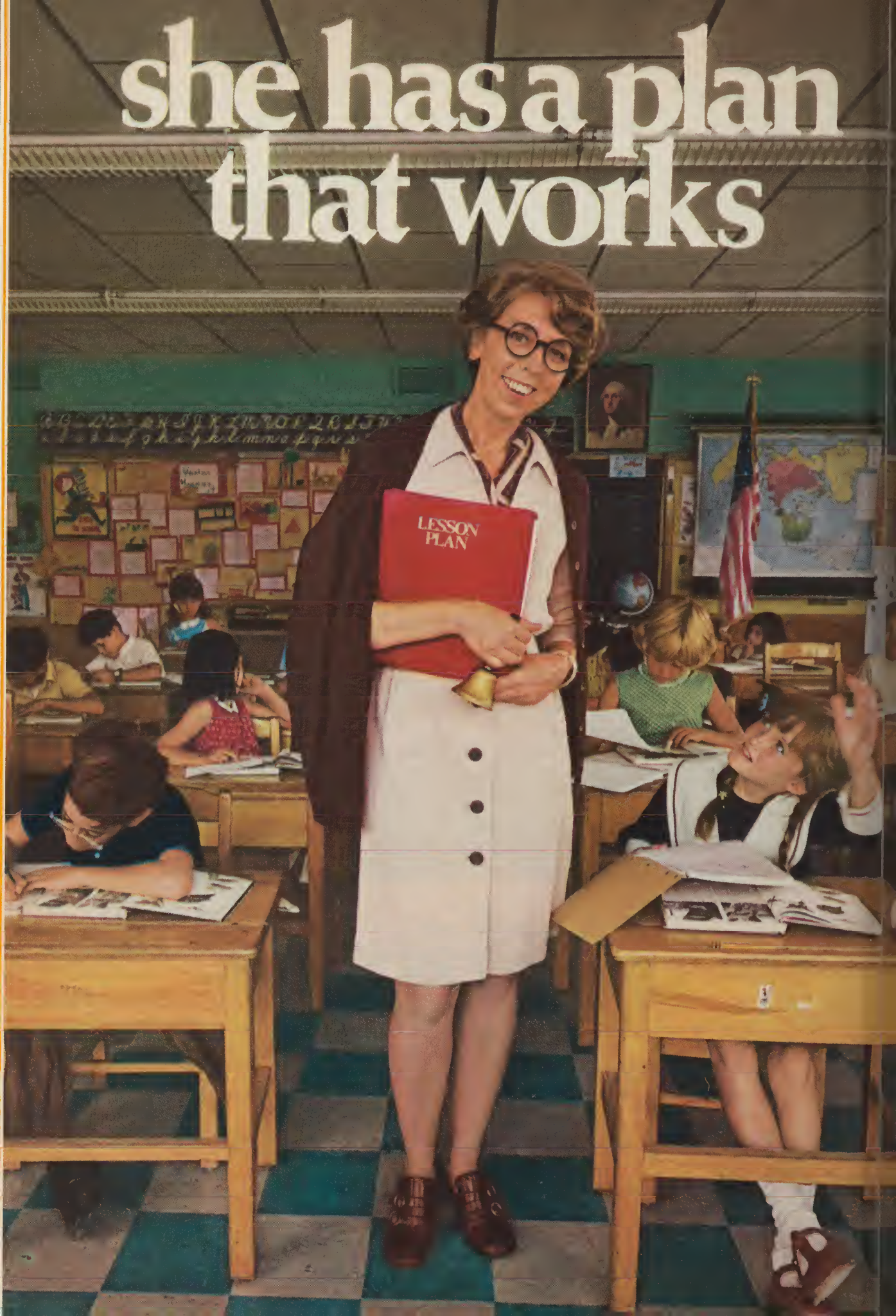
she has a plan that works



She has a plan that works.

She has one plan for the ass. And they really respond.

She has another plan just r herself. A medication plan r her hypertension. And she's so responding beautifully.

More than just another tihypertensive, Ser-Ap-Es n be a whole medication plan r living with hypertension.

Does it get good marks for mfort?

Excellent. Because r-Ap-Es controls blood pres- re effectively, dosage of each mponent is lower than if pre- ribed alone, usually minimiz- g side effects. However, side fects may occur (see prescrib- g information).

Designed with the kidney mind?

Hydralazine maintains increases renal blood flow.

And the brain too?

Hydralazine also relaxes rebral vascular tone. And serpine has beneficial calm- g action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

Practical on a teacher's salary?

Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits…

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

C I B A

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

a plan for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

INDICATIONS: All cases of hypertension except the mildest and the most severe.

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

Hydralazine: Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Reserpine: The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydralazine: Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

Hydralazine: Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Reserpine: Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

Hydralazine: Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

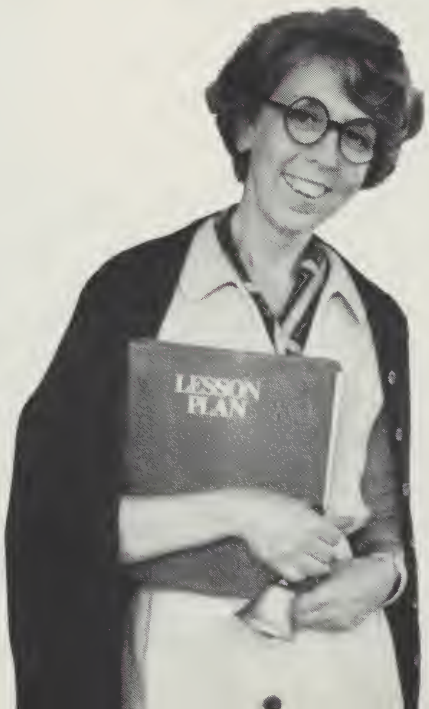
Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE: One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

SUPPLIED: *Tablets* (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901 —2/4624-1 17



she has a plan that works for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

CIBA

On formulary and in the pharmacy...

take advantage of the

Kantrex®
KANAMYCIN SULFATE

experience

A dozen years of Kantrex usage have established its efficacy, its versatility, its simplicity.

And its economy.

Faced with a life-threatening infection, the physician cannot conscionably consider economy a primary factor in selection of an appropriate antibiotic. However, when susceptibility reports are in, the infecting pathogens are often found to be susceptible to several antibiotics. The physician may then consider dose requirements and cost in his prescribing decision.

Kantrex requires one simple standardized dose for almost any patient with any susceptible mixed Gram-negative/staph infection (Pseudomonas are resistant). The usual adult daily dose of Kantrex is only 1.0 Gm....and the usual total course of therapy, 7-10 Gm. Translated to dollars and cents, the daily cost of Kantrex therapy may be only 1/2 to 1/8 that of therapy with other parenteral antibiotics used for serious hospital infections.

Doesn't it make good sense to use Kantrex?

Experience proves it does.

IEF SUMMARY OF PRESCRIBING INFORMATION
7/27/71
r complete information, consult Official Package Circular.

Warning: The major toxic effect of parenterally administered kanamycin sulfate is its action on the auditory portion of the eighth nerve. High frequency deafness usually occurs first and can be detected by audiometric testing. Tinnitus or vertigo may occur and are evidence of vestibular injury and impending bilateral, irreversible deafness. In such cases, decrease size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. Watch carefully for ototoxicity in older patients and patients receiving more than 15 Gm. of kanamycin. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in postoperative patients until recovery from anesthesia and muscle relaxants is complete. Avoid concurrent use of other ototoxic drugs including ethacrynic acid and furosemide. Safety in pregnancy is not established.

dications: Serious infections due to susceptible strains of *E. coli*, Proteus ., *Enterobacter aerogenes, K. pneumoniae, Serratia marcescens* and *ma-Herellea*. Culture and sensitivity studies should be performed.
ntraindications: A history of hypersensitivity to the drug. Prior auditory mage by kanamycin or other agents may be a contraindication if effective, ternative therapy is available.

Precautions: Obtain audiograms before and during therapy in patients with renal dysfunction when treatment lasts more than 5 days. Stop Kantrex if tinnitus or hearing loss occurs. Hydrate patients to prevent chemical irritation of the renal tubules. Assess renal function periodically, both before and during therapy. If signs of renal irritation occur (casts, cells, proteinuria) increase hydration and reduce the dosage or the frequency of dosage if necessary. In azotemic patients, the frequency (in hours) of doses may be obtained by multiplying the serum creatinine by 9. If azotemia or oliguria occur, discontinue therapy. Mycotic or bacterial superinfection may occur.
Adverse Reactions: Irritation or pain at the injection site, skin rash, drug fever, headache and paresthesias.
Dosage and Administration: The usual dose is 7.5 mg./Kg./12 hours I.M. The average dose is 1 Gm. daily for adults and children. The maximum total daily adult dose should not exceed 1.5 Gm. by all routes of administration. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 3 to 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours. The drug should not be physically mixed with other antimicrobials.
Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations; 0.5 Gm. in 2 ml. 1.0 Gm. in 3 ml. Also available—Pediatric Injection 75 mg. in 2 ml. **A.H.F.S. Category 8:12.28**

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

Facts about Loridine® I.M. cephaloridine

Facts about activity

Loridine is indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed below.* It is active against the following organisms in vitro:

Beta-hemolytic and other streptococci (many strains of enterococci, e.g., *Streptococcus faecalis*, are relatively resistant)
Staphylococci, both coagulase-positive and coagulase-negative (some strains of staphylococci are resistant to cephaloridine)
Pneumococci
Gonococci
Hemophilus influenzae
Escherichia coli and other coliform bacteria
Klebsiella
Proteus mirabilis

Loridine also has demonstrated activity against *Treponema pallidum* in experimental syphilis studies in animals.

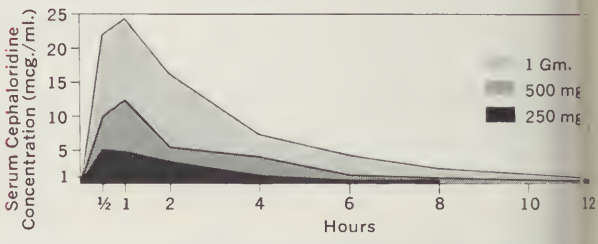
All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine. However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *H. influenzae*, *Pr. mirabilis*, *Esch. coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

*Loridine is indicated in the treatment of gonorrhea when penicillin is not considered the drug of choice.

Facts about dosage

In adults, most infections of moderate severity caused by susceptible organisms respond to Loridine in dosages ranging from 500 mg. to 1 Gm. every eight hours (1.5 to 3 Gm. daily). This use of lower dosages helps prevent drug accumulation. The more susceptible infections have been treated with 250 to 500 mg. every eight hours.



Mean Serum Cephaloridine Concentrations after I.M. Administration of Single Doses (250 mg. to 1 Gm.) to Normal Human Volunteers (Six to Eighteen Subjects per Group). (Modified from Currie, J. P.: Cephaloridine: Pharmacology and Toxicology, Postgrad. M. J., 43 [Supplem.]: 22, 1967.)

Peak serum levels have been noted with Loridine within one-half to one hour following I.M. injection. The mean peak serum levels obtained in normal subjects one hour after a 500-mg. I.M. dose ranged from 12 to 22 mcg. per ml. in separate studies. Administration every six to eight hours permits adequate concentrations to be maintained. In order to avoid excessive serum levels (which could possibly result in damage to the kidney tubules), recommended dosages should not be exceeded. In adult patients without azotemia who have mildly reduced renal function manifested by slight to moderate transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the *maximum* recommended dosage is 1 Gm. every twelve hours during the period of reduced function.

acts about administration

e following guidelines for therapy with idine are recommended.

fore Administration of Loridine

Establish susceptibility of the pathogen.

Determine patient's renal status; Loridine is contraindicated in azotemia.

ring Administration of Loridine

Maintain proper hydration.

Monitor renal status —urinalyses, urinary output, BUN, and/or serum creatinine.

Use cautiously with other potentially nephrotoxic drugs.

Because nephrotoxicity has been reported, limit dosage to 4 Gm. daily for adults (100 mg. per Kg. for children—not to exceed adult dosage). Usual adult dosage range: 1 to 3 Gm. daily.

5. In patients with impaired renal function *before* treatment, reduce daily dosage and keep them under close observation for changes in function. In nonazotemic patients with mildly reduced renal function manifested by slight to moderate, transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the *maximum* recommended dosage (adults) is 1 Gm. every twelve hours during the period of reduced function.
6. In patients who develop impaired renal function or whose preexisting impairment becomes worse *during* treatment, discontinue therapy.

Since Loridine is relatively painless on I.M. injection, it is well accepted by patients.

There is clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins; therefore, Loridine should be used with great caution in patients with known penicillin allergy. Instances of patients who have had severe reactions to both drugs, including death from anaphylaxis, have been reported.

Loridine® I.M.
cephaloridine

Lilly

101553

(Please turn page for prescribing information.)

Loridine® I.M.
cephaloridine

Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae*, *Proteus mirabilis*, *Escherichia coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (*see* Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 60 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. 10E-91

Additional information available to the profession on request.

Eli Lilly and Company
Indianapolis, Indiana 46206

101553

With EVAC-U-GEN your patients with functional constipation can evacuate gently. This is highly desirable for those sensitive to harsh laxatives . . . particularly children, pregnant women, and geriatric patients

EVAC-U-GEN®

CHEWABLE
VERY PALATABLE
ECONOMICAL

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): 1/2 tablet. A citrus drink taken with tablet will stimulate action.

PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

WALKER, CORP. & CO., INC. Syracuse, New York 13201

Cleopatra and Caesar, Wine Lovers

...a story that every Doctor and Nurse should know.

Julius Caesar 102–44 B.C.

Cleopatra, 69–30 B.C. For their first secret meeting, she had herself "delivered" to Caesar rolled up in a rug.

JULIUS CAESAR wasn't a doctor, but thanks partly to the wiles of a young woman named Cleopatra — who wasn't a nurse — he changed the history and the practice of medicine!

(Incidentally, Caesar was a tremendous influence in wine, too. He sponsored plantings in conquered lands which were to become France, Germany, Italy, Switzerland, Spain and Portugal — the six nations from which California derives its classic vine and its wine traditions.)

To compress history just a bit, here's how Caesar did it:

Visiting Egypt, he dallied with Cleopatra in Alexandria (48–47 B.C.), and sired their son Caesarion. He also observed the wondrous university where Cleopatra's Ptolemaic Dynasty had preserved Greek medical and scientific treasures for three centuries—including the teachings of Hippocrates!

Impressed by Greek genius (Cleopatra was Greek, too, remember), Caesar returned to Rome and freed the Greek doctor slaves. This gave them Roman citizenship and the right to practice. They brought into Rome's primitive patient care more modern precepts, ethics, diagnostics, and wine therapy, thus raising medical standards for the next twenty centuries.

His fascinating lady friend had moved to Rome, and they might have lived happily ever after—but remember the Ides of March, 44 B.C.—*Thou too, Brutus? Then fall, Caesar!* . . . And sadly Cleopatra Ptolemy never became Mrs. Julius Caesar, queen of the world.

At his death, Caesar was not only master of the world, but its best known wine connoisseur. Two ye before, he had celebrated a triu (Dictator for Life), inviting everybo in Rome to a feast, and serving th *four* famous vintage wines, those Falernum, Chios, Mamertinum, a the wine of Lesbos.

MORE WINE READING?

Below is our latest selection of rea ings on wine in patient care, for Do tor, Nurse, and Staff. Also, some "fu booklets on wine cooking, servi tasting and entertaining—to make y the veritable Caesar or Cleopatra your own home!

Just circle the subjects you wi They are yours free. And thank y for your generous response to o previous wine messages.

The Winegrowers of Californi

WHAT IS WINE?

Wine is nature's own food, tonic and giver of hope; available to rich and poor, for Doctor, Nurse, and patient alike; a gentle tranquilizer which can augment the sense of well-being without diminishing the will. Wine is easy to prescribe and give and enjoy. Wine is yours, Doctor and Nurse, for your personal pleasure, for your patients' more cheerful recovery in hospital or home.

WINE READING PRESCRIPTION, filled without charge for Doctor, Nurse, Assistant, Administrator, Dietician, or other members of the medical profession:

Circle each number wanted:

1 A 160-page paperback book that every Doctor, Nurse, Dietician and Hospital Administrator should own. WINE AND YOUR WELL-BEING, by Salvatore P. Lucia, M.D., a practicing physician and Professor of Medicine, Emeritus, University of California. This noted authority on wine in therapy gives you clinical information on wine in convalescence, in geriatrics, stress, cardiovascular disorders, diabetes, etc. Other subjects are: what wine is, how made, food values, calories, wine in restricted diets (with some recipes), bits of intriguing wine history, seasoned with famous wine quotations, a list of wines and how they taste. Yours with our compliments.

2 USES OF WINE IN MEDICAL PRACTICE, 64 pp.; contains references to the results of 30 years of scientific medical research in U.S. and abroad on wine in nutrition, convalescence, gastroenterology, various clinical conditions, covers Indications, Contraindications, Bibliography, wine in Hospital and Nursing Homes.

3 WINE COOKERY THE EASY WAY, 24 pp., 53 recipes for "gourmet meals in a hurry" with convenience foods; and CALIFORNIA WINE COOKERY AND DRINKS, 24 pp., 88 recipes, ideas, for home fun of good cooking, serving, and entertaining. Both booklets free.

PLEASE PRINT YOUR NAME, title as member of me cal profession, address and zip, and mail to:

DEPARTMENT 113 WINE ADVISORY BOAR
717 MARKET STREET, SAN FRANCISCO, CA 941

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Title_____

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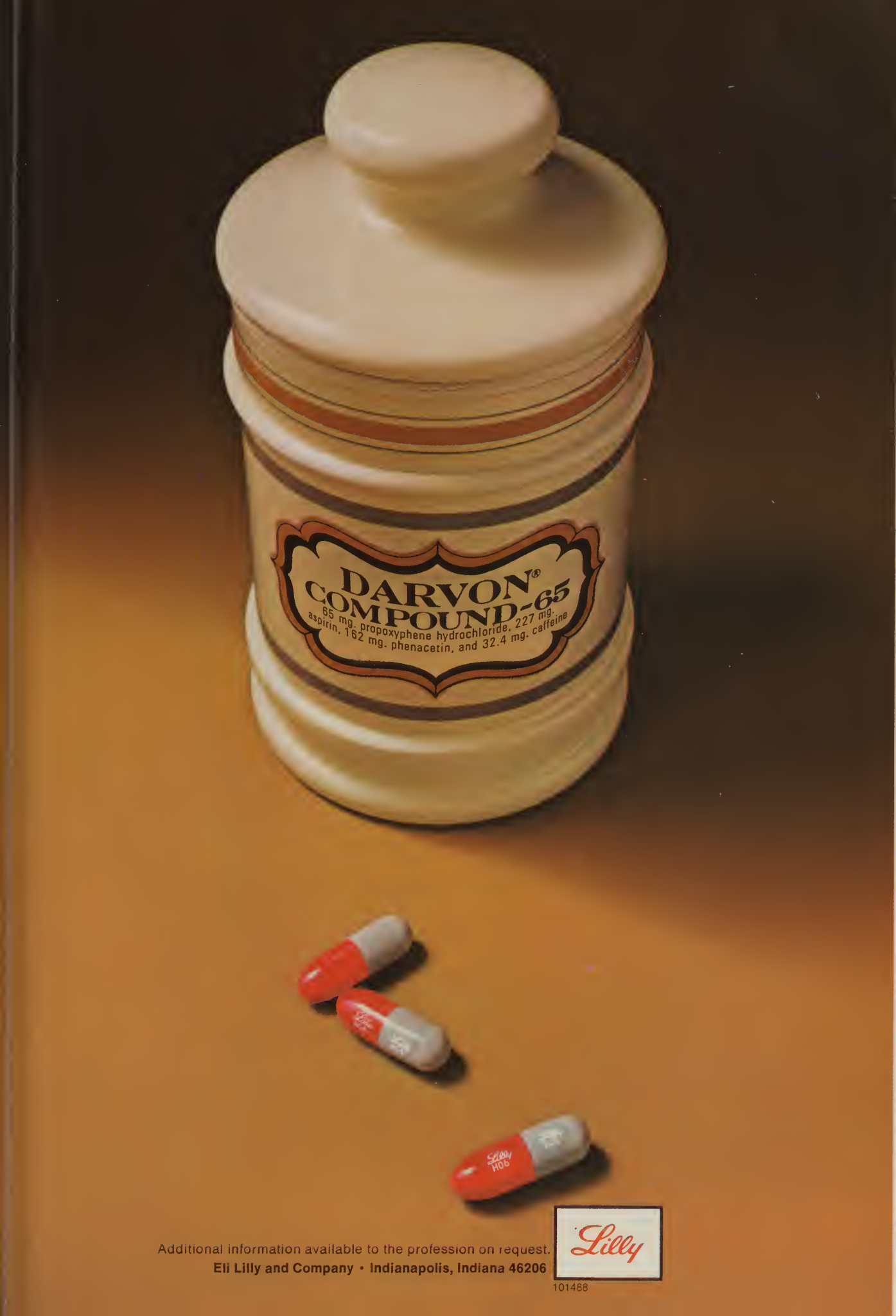

Additional information available to the profession on request.

Eli Lilly and Company • Indianapolis, Indiana 46206

Lilly

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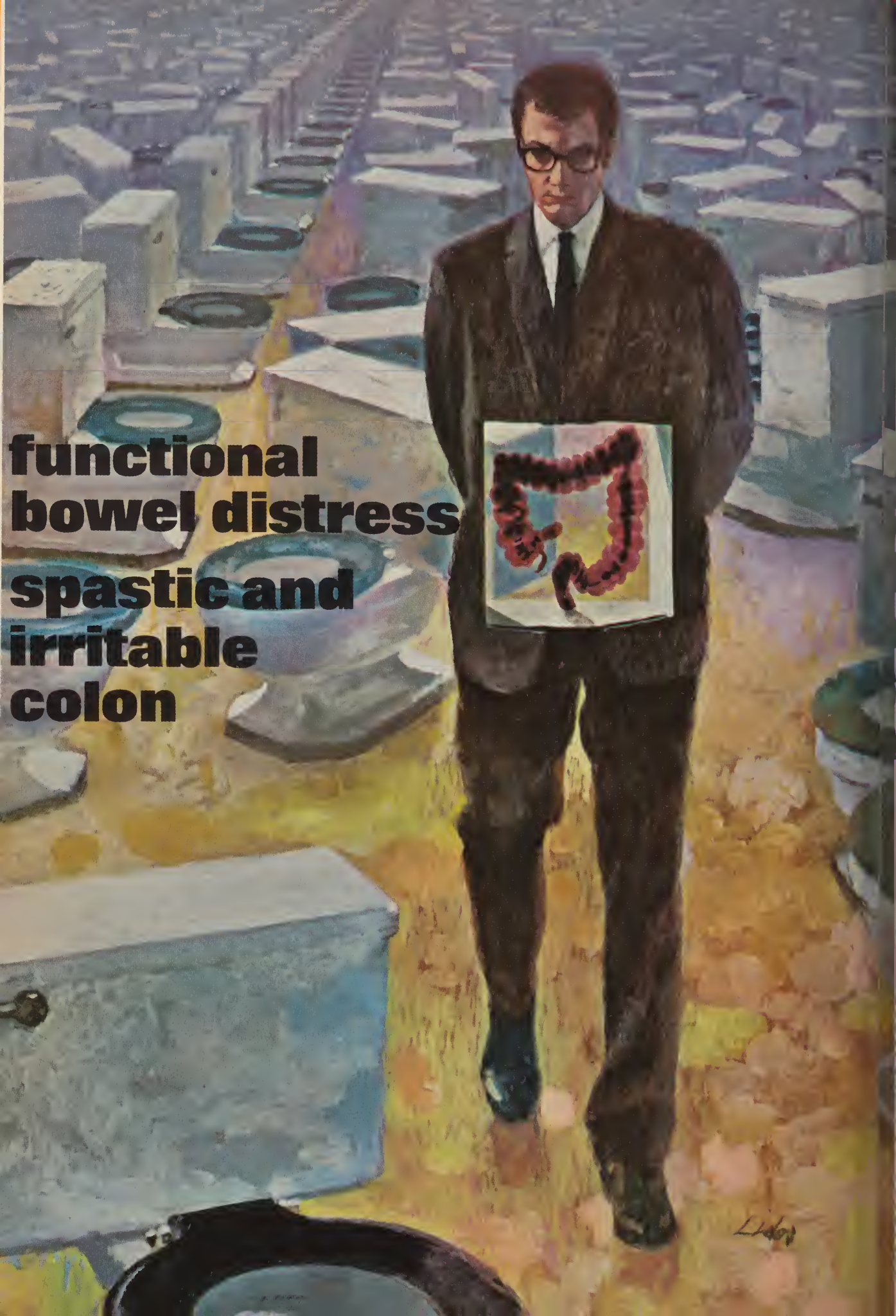

functional
bowel distress
spastic and
irritable
colon

move up to "the Robinul response"

In treating hypermotility associated with functional lower G-I disorders are you disappointed in the results you've been getting with some of the synthetics? Then *move up* to a potent antispasmodic—Robinul® Forte (2 mg. glycopyrrolate). It provides prompt, pronounced, prolonged suppression of hypermotility, making it a highly effective agent in functional bowel distress, as well as in spastic and irritable colon. Robinul Forte also exerts a more selective action on the gastrointestinal tract. If the patient has a "one tract mind" concerning his lower G-I symptoms, you can help control the anxiety and tenseness by prescribing Robinul®-PH Forte (2 mg. glycopyrrolate with 16.2 mg. phenobarbital —warning: may be habit forming).

when lower G-I symptoms demand a potent synthetic antispasmodic

Robinul® 2 mg. Forte (glycopyrrolate)

NDICATIONS Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily cated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with te episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities ilable, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recom-nded in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic ncreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure drome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital y be indicated. ■ CONTRAINDICATIONS Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric reten-n, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH te (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ PRECAUTIONS Administer with caution in the presence of incipient ucoma. ■ SIDE EFFECTS The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving o 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. ırred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic gs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsi-ss, and rash. ■ DOSAGE The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one let three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual tient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum quired to maintain symptomatic relief. ■ SUPPLY Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved R/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue lets engraved AHR/2 in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. A·H·ROBINS

if skin is infected, or open to infection...

choose the topicals that give your patient–

- broad antibacterial activity against susceptible skin invaders
- low allergenic risk—prompt clinical response

Special Petrolatum Base
Neosporin® Ointment
(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® brand polymyxin B sulfate, 5000 units; zinc bacitracin, 400 units; neomycin sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); special white petrolatum q. s.
In tubes of 1 oz. and ½ oz. for topical use only.

Vanishing Cream Base
Neosporin®-G Cream
(polymyxin B-neomycin-gramicidin)

Each gram contains: Aerosporin® brand polymyxin B sulfate, 10,000 units; neomycin sulfate, 5 mg. (equivalent to 3.5 mg. neomycin base); gramicidin, 0.25 mg., in a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, purified water, and 0.25% methylparaben as preservative.
In tubes of 15 g.

NEOSPORIN for topical infections due to susceptible organisms, as in impetigo, surgical after-care, and pyogenic dermatoses.

Precaution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: Not for use in the external ear canal if the eardrum is perforated. These products are contraindicated in those individuals who have shown hypersensitivity to any of the components.

Complete literature available on request from Professional Services Dept. PML.

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

m.d.'s in the news

Herbert Blough, M.D., Philadelphia, sociate professor of ophthalmology d head of the division of biochemical rology and membrane research at the niversity of Pennsylvania Medical hool, presented a paper on "Neutral pid Turnover in Chick Cells and Ef- ct of Influenza Virus" to the Interna- nal Congress of Virology in dapest, Hungary. In addition to his ork on the "flu" virus, Dr. Blough is ing research on herpes simplex and bella viruses.

Commendations for excellent medi- l care of veterans returning from ietnam have been given to three medi- l officers of Valley Forge General ospital in a joint resolution adopted the Connecticut State Legislature. ited were **Col. Philip A. Deffer, M.D.**, ief of the department of surgery and thopedic services, and **Lt. Col. homas H. Witschi, M.D.**, and **Maj. anley L. Grabias, Jr., M.D.**, both or- opedic surgeons.

Harry C. Bishop, M.D., Philadel- ia, has been elected president of the edical staff of Children's Hospital, hiladelphia.

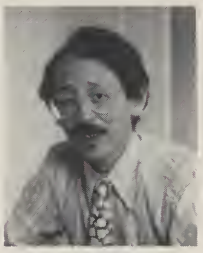
Chester M. Southam, M.D., New ork City, has been selected as rector of the division of medical ncology in the Department of Medi- ne and professor of medicine at Jef- rson Medical College, Thomas Jef- rson University, Philadelphia.

Three physicians have joined the culty at Milton S. Hershey Medical enter of Pennsylvania State Universi- . as assistant professors. **David M. eaman, M.D.**, Lancaster, was for- erly a cardiopulmonary fellow at the niversity of Vermont; **Allan Lipton, I.D.**, New York City, was an Ameri- an Cancer Society Dernham fellow at he Salk Institute of Biological Studies; nd **Richard J. Santen, M.D.**, Cincin- ati, Ohio, was an instructor in in- rnal medicine at the University of Vashington, Seattle, and a fellow in ndocrinology with the U.S. Public Health Service.

St. Christopher's Hospital for Children, Philadelphia, has announced everal appointments to its staff. **Rich- rd M. Goldstein, M.D.**, Philadelphia, as joined the medical staff as pediatri- cian with the Model Cities Project. He was also appointed an assistant professor of pediatrics at Temple University School of Medicine. **V.L. Shashikumar, M.D.**, Philadelphia, was appointed to the surgical staff as clinical instructor in pediatric surgery. **Joseph S. Torg, M.D.**, Philadelphia, has been made co-director of the orthopedics section to succeed **Theodore R. Lammot, III, M.D.**, Merion, who is moving to Fort Collins, Colorado, to join the orthopedic staff at Poudre Memorial Hospital.

Howard Balin, M.D., Philadelphia, will direct the new Philadelphia Consortium for Population Research established by the Franklin Institute.

DR. BALIN



DR. KARP

Robert Karp, M.D., Mount Airy, has been selected as physician for Philadelphia School District's Follow-Through program in North Philadelphia. The program is under the supervision of St. Christopher's Hospital for Children and is aimed at providing service for youngsters not qualified geographically for the hospital's neighborhood health clinics.

Herbert J. Kaufmann, M.D., former director of the Department of Radiology at Children's Hospital of the University of Basel in Switzerland, has been appointed radiologist-in-chief of Children's Hospital, Philadelphia, and professor of pediatric radiology at the University of Pennsylvania School of Medicine.

Alvin P. Shapiro, M.D., professor of medicine at the University of Pittsburgh School of Medicine, has been appointed associate dean for academic affairs. He had been chief of clinical pharmacology, hypertension section, and director of the Department of Medicine's psychosomatic program since 1960.

Thomas J. Gill, III, M.D., has been appointed professor and chairman of the pathology department at the University of Pittsburgh School of Medicine and pathologist-in-chief of the University Health Center in Pittsburgh. He came to Pittsburgh from Boston, Mass., where he was an assistant professor of pathology at Harvard Medical School and a senior associate in pathology at the Peter Bent Brigham Hospital.

Thomas H. Johnson, M.D., Pittsburgh, has been promoted from assistant to associate professor of radiology at the University of Pittsburgh School of Medicine. Dr. Johnson won first prize for his exhibit on laryngography of benign lesions at a meeting of the Pennsylvania Radiological Society in May at Bedford Springs.

Charles S. Cameron, M.D., Philadelphia, has moved from president of Hahnemann Medical College and Hospital to chairman of the board.

John J. Evans, M.D., Nesquehoning, has replaced the late J.M. Steele, M.D., as chief of surgery at Coaldale State General Hospital. **James Farr, M.D.**, Lehighton, has also joined the Coaldale staff with priveleges in obstetrics, gynecology, and newborn care. Dr. Farr is a fellow in the American College of Surgeons and the American College of Physicians.

Gary Lyons, M.D., Port Allegheny, has been appointed chief of thoracic and cardiovascular surgery at St. Vincent Hospital. He is a member of the American Board of Surgery and the Board of Thoracic Surgery.

Josiah F. Reed, Jr., M.D., Harrisburg, has moved to Montgomery, Ala. His last assignment in the U.S. Air Force was as chief of urology at the U.S.A.F. Regional Hospital at Maxwell Air Force Base in Montgomery.

Aureliano Rivas-Flores, M.D., Wayne, was the first Puerto Rican to be promoted to brigadier general in the U.S. Army Reserve Corps. He is chief of surgery at Pottstown Memorial Medical Center and practices urology in Philadelphia and Pottstown.

Edward S. Cooper, M.D., Claysville, has received Meharry Medical College's distinquished alumni award. Dr. Cooper is co-director of the Stroke

Research Center of Philadelphia General Hospital and associate professor of medicine at the University of Pennsylvania School of Medicine.

Albert B. Ferguson, M.D., Pittsburgh, received the R.H. Nimmo Award from the Royal Australian College of Surgeons. The award is a visiting professorship given to an outstanding medical educator. Dr. Ferguson is professor of orthopedic surgery and chairman of the department at the University of Pittsburgh School of Medicine.

Brigadier General William D. Prescott, M.D., Pine Grove, was awarded the Army and Air National Guard Meritorious Service Plaque. He is assistant adjutant general for Air Headquarters in the Pennsylvania Air National Guard and a practicing physician in Pine Grove.

Leroy A. Rodgers, M.D., Johnstown, has been elected president of the Cambria County Unit of the American Cancer Society. The new president of the Jefferson County Unit is **A.E. Devlin, M.D.,** Brockway.

F.D. Gassaway, M.D., who is medical director of Gulf Oil Corporation in Pittsburgh, served for two months in Vietnam under AMA's Volunteer Physicians for Vietnam program recently.

Robert E. Brant, M.D., Phoenixville, was presented with the U.S. Army Outstanding Civilian Service Medal for his services as consultant in surgery for the Surgeon General for the past twenty years.

Charles G. Francos, M.D., Lancaster, has been named physician and director of the medical division at Franklin and Marshall College Health Services to succeed **James Z. Appel, M.D.** Dr. Appel was granted emeritus status for his thirty-five years of service in the position.

Joseph R. DiPalma, M.D., Wayne, dean of Hahnemann Medical College, has completed editing the fourth edition of *Drill's Pharmacology in Medicine*, which will be translated into Spanish and Italian.

Harold E. Pierce, Jr., M.D., Yeadon, has been promoted to full colonel in the Pennsylvania Air National Guard. He is a member of the Association of Military Dermatologists and is president of the Alliance of Air National Guard Flight Surgeons.

Gene J. Triano, M.D., has been appointed head of the Department of Radiology at Harrisburg Hospital. He is clinical professor in radiology at the Milton S. Hershey Medical Center of Pennsylvania State University. He will also direct the Harrisburg Hospital School of Radiologic Technology.

Two further appointments have been announced by the Milton S. Hershey Medical Center of Pennsylvania State University. **Robert W. Brennan, M.D.,** Staten Island, N.Y., has been appointed associate professor of medicine and chief of neurology. He was formerly an assistant professor at Cornell University Medical College in New York City. **Cheston M. Berlin, Jr., M.D.,** Mt. Lebanon, has been named associate professor of pediatrics. He was formerly assistant professor of pediatrics at George Washington University School of Medicine and director of the intensive care unit at Children's Hospital in Washington, D.C.

DR. BERLIN

DR. CARTER

Joseph H. Carter, Jr., M.D., York, has been elected a fellow by the American College of Obstetrics and Gynecology. He is coordinator of the York Hospital Department of Obstetrics and Gynecology and senior clinical instructor in obstetrics and gynecology at Hahnemann Hospital, Philadelphia.

Edward J. Benz, M.D., was elected volunteer medical director of the Miller Blood Center at the Muhlenberg Medical Center. This new center will collect, process, and store all blood and components for six Lehigh Valley hospitals.

William A. Nickles, M.D., Shippensburg, is phasing out his private practice to assume duties as the first full-time health director for Shippensburg State College.

Children's Hospital of Philadelphia has announced the appointment of several physicians. **George Polgar, M.D.,** has been named director of the pulmonary disease division. He is associat professor of pediatrics and physiolog at the University of Pennsylvani School of Medicine. **Charles R. Koch M.D.** was named psychiatrist-in-chie He had been a staff psychiatrist c Children's and child psychiatrist in th Philadelphia Child Guidance Clinic.

Dean E. Burget, M.D. has bee selected as chief of the newly create division of plastic and reconstructiv surgery at Hahnemann Medica College and Hospital, Philadelphia. H will also be an assistant professor o the faculty of the Department of Sur gery.

Robert T. Rubin, M.D. was ap pointed professor of psychiatry at th Milton S. Hershey Medical Center o the Pennsylvania State University. H was a member of the Brain Researcl Institute at UCLA and a consultant fo the U.S. Navy Medical Neuropsychia tric Research Unit in San Diego, Cal.

Stanley P. Mayers, Jr., M.D., ha joined the faculty at Pennsylvani State University as professor of healt care planning at the College of Huma Resources in Arlington County, Vir ginia. He is a diplomate of the Ameri can Board of Preventive Medicine.

Eduardo J. Yunis, M.D., has bee promoted to associate professor of pa thology at the University of Pittsburg School of Medicine.

Grace S. Gregg, M.D., has been ap pointed assistant dean for student af fairs at the University of Pittsburg School of Medicine and has bee promoted to associate professor of pe diatrics. Dr. Gregg is a member of th teaching faculty of the Pittsburg School of Health Related Profession and is on the advisory council of th Infant Learning Project at the Pitts burgh Graduate School of Publi Health.

John S. Bray, M.D., is now directo of the division of medicine at th Polyclinic Hospital, Harrisburg. He i also chief and coordinator of th department of cardiology and chief o internal medicine.

The new director of Family an Children's Service of the Lebanon County Mental Health-Mental Retar dation Program is **Abram M. Hos tetter, M.D.,** Annville. He is a Penn sylvania delegate to the American Psy chiatric Association.

new members

LLEGHENY COUNTY:
age Van Horn, M.D., 322 Scaife Hall, Pittsburgh 15213.
rendra K. Bansal, M.D., Mercy Hospital, Pittsburgh 15219.
avid H. Barnhouse, M.D., 238 Park Entrance Dr., Pittsburgh 15228.
seph G. Antkowiak, M.D., Apt. 52, 5254 Centre Ave., Pittsburgh 15232.
erald J. Broock, M.D., 532 Tyler St., Pittsburgh 15237.
alanmay Ghoshhajra, M.D., 152 Oakville Dr., Apt. TB 4, Pittsburgh 15220.
yrus Ilkhanipour, M.D., Mercy Hospital, Pittsburgh 15219.
arhad Ismail-Beigi, M.D., 3700 Fifth Ave., Pittsburgh 15213.
aher A. Dajani, M.D., 1629 Union Ave., Natrona Heights 15065.
ee C. Dobler, M.D., 526 Perrysville Ave., Pittsburgh 15229.
ernard H. Sobol, M.D., 5612 Melvin St., Pittsburgh 15217.
ictor R. Marquez, M.D., 5261 Greenridge Dr., Pittsburgh 15236.
ishpal Singh, M.D., 1191 Scaife Hall, Pittsburgh 15213.
ofronio J. Valcarcel, M.D., 4800 Friendship Ave., Pittsburgh 15224.
tanley B. Morgenlander, M.D., 3347 Forbes Ave., Pittsburgh 15213.
Villiam J. Tiegel, M.D., 101 Emerson Ave., Pittsburgh 15215.
enn Lupovich, M.D., M.D., 6313 Kentucky Ave., Pittsburgh 15206.

RMSTRONG COUNTY:
ames E. Bauer, M.D., 1300 Carlisle St., Natrona Heights 15065.

ERKS COUNTY:
illiam A. Sweet, M.D., 606 Museum Rd., Reading 19602.

UTLER COUNTY:
wang Yop Kim, 531 Pershing Dr., New Kensington 15068.

RIE COUNTY:
ennis G. Cole, M.D., 406 Peach St., Erie 16507.

AYETTE COUNTY:
dwin S. Peters, M.D., 610 N. Main St., Masontown 15461.

UNTINGDON COUNTY:
ack F. Bailey, M.D., Taylor Highlands, Huntingdon 16652.
scar R. Silva, M.D., J.C. Blair Memorial Hospital, Huntingdon 16652.

ACKAWANNA COUNTY:
eorge C. Potash, M.D., 431 Wyoming Ave., Scranton 18503.
obert Rosenbluth, M.D., 748 Quincy Ave., Scranton 18510.
oseph P. Andriole, M.D., 748 Quincy Ave., C-3, Scranton 18510.

EBANON COUNTY:
obert J. Ryan, M.D., 231 E. Main St., Palmyra 17078.
lbert A. Alley, M.D., 12th and Oak Sts., Lebanon 17042.
tephen J. Solomon, M.D., 618 Cornwall Rd., Lebanon 17042.

EHIGH COUNTY:
hung H. Lee, M.D., 17th and Chew Sts., Allentown 18102.

McKEAN COUNTY:
Vincent D. Lau, M.D., 401 Minard Run Rd., Bradford 16701.
Danilo L. Guanzon, M.D., Odd Fellows Bldg., Bradford 16701.

MONTOUR COUNTY:
J. Scott Martin, M.D., Box 199, R.D. 1, Northumberland 17857.

PHILADELPHIA COUNTY:
Frank Garbak, M.D., Temple University Hospital, Philadelphia 19140.
Henry A. Gorman, M.D., Buffalo Valley Nursing Home, Box 41, Lewisburg 17837.
Jannetta V. Connor, D.O., 1808 Janney Terrace, Langhorne 19047.
Joseph P. Connor, D.O., 1808 Janney Terrace, Langhorne 19047.
Edgardo S. Alday, M.D., 1025 Walnut St., Philadelphia 19107.
Rosario Resurreccion, M.D., 5831 N. Camac, Philadelphia 19141.
Ellis J. Lindenbaum, D.O., 1101 Morefield Rd., Philadelphia 19115.
Peter H. Morse, M.D., 3400 Spruce St., 329 Gate East, Philadelphia 19104.
John L. Neigh, M.D., 520 Fairfax Rd., Drexel Hill 19026.
Kathryn M. Hess-Feldi, M.D., 60 Wayne Ave., Wayne 19087.
E. Paul Kitchin, M.D., 302-C Aldin Manor, Philadelphia 19144.
Stephen E. Reznak, M.D., 3120 S. Schoolhouse Lane, Philadelphia 19144.
Laurian Roman, M.D., 4000 Gypsy Lane, Apt. 301, Philadelphia 19144.
Lois Martyn, M.D., 88 E. Bringhurst St., Philadelphia 19144.
Fred G. Medinger, M.D., Abington Hospital, 1245 Highland Rd., Abington 19001.
Marvin R. Hyett, M.D., 2035 Locust St., Philadelphia 19103.
Ray F. Garman, M.D., Graduate Hospital, University of Pennsylvania, Philadelphia 19146.
Michael A. Gordon, D.O., 207 A, Cedarbrook Hill, Philadelphia 19150.
Petro Fedoriw, M.D., 4733 N. 12th St., Philadelphia 19141.
W. Robert Felix, Jr., M.D., 3300 Henry Ave., Philadelphia 19072.
Barry D. Lang, M.D., 701 Summit Ave., Apt. D-14, Philadelphia 19128.
James A. Hagans, M.D., 204 Berwick Place, Lansdale 19446.
Henry L. Price, Jr., M.D., 230 N. Broad St., Philadelphia 19102.
Chong Park, M.D., 5555 Wissahickon Ave., Apt. 701, Philadelphia 19144.
George L. Popky, M.D., 3134 W. Coulter St., Philadelphia 19129.
Marcus M. Reidenberg, 3420 N. Broad St., Philadelphia 19140.

POTTER COUNTY:
Boonlua Ratanawongsa, M.D., Charles Cole Memorial Hospital, Coudersport 16915.

VENANGO COUNTY:
Salustiano F. Mendoza, M.D., 9 Glenview Ave., Oil City, 16301.
Humberto Alarcon, M.D., 119 W. Front St., Oil City 16301.

WARREN COUNTY:
Boonmee Enkvetchakul, M.D., 1209 Conewango Ave., Warren 16365.
Roger Walentiny, M.D., Northwest Savings Bldg., Warren 16325.
Jon H. Rouch, M.D., Box 249, Warren 16365.

Fuel to Keep Us Moving

As a result of the action taken by the House of Delegates of the Pennsylvania Medical Society at the Annual Session in Pittsburgh, a dues increase of $25.00 was approved. This action was approved unanimously by the House, upon the recommendation of the Finance Committee and Board of Trustees.

This increase is necessary— and for good reasons. Chief among these are the continuing and accelerating effects of inflation on operating costs since 1963 when the last increase was approved, and the ever-increasing importance of the Society's activities to ensure quality medical care at reasonable cost.

The public's concern about rising health care costs is well known to physicians. Failure on the part of the physician to join forces with all segments of society interested in providing health care at a reasonable cost can lead only to a deterioration of our present health care system. If the health care profession is to be responsible and responsive to the public interest physicians who are elected or appointed as representatives of the organized profession must have a vehicle through which it can be effective in health affairs. Sufficient money is required to fuel the vehicle— money which is wisely spent by an organization designed and staffed to give maximum performance.

As Dr. David S. Masland, chairman of the Finance Committee, pointed out in his presentation, "there has been no empire building." The Society's employees in 1963 num bered forty-two. Today there are forty-one. Despite the stabl number of employed staff, significant new programs hav been developed including 1) the establishment of a cor tinuing education foundation to initiate, promote, an improve continuing education programs for practicin physicians; 2) establishment of a medical care foundation t assist in coping with health care costs; 3) a pioneering ma practice insurance program for Pennsylvania physicians, an 4) more television documentaries to present a reasonable an factual approach to the health care problems facing the Penn sylvania public.

By comparison with other state societies, two-thirds ha dues higher than the Pennsylvania Medical Society in 197(Even with the increase in PMS dues, 40 percent will hav higher dues in 1971.

What effect the wage and price freeze will have on th increase remains to be determined. However, the needs of th Society are such that an increase cannot be considered infla tionary. It thus becomes obvious that if Pennsylvani physicians want their voices heard for the benefit of th public, then our Society will continue to need the financia support and generous contributions of time and effort of a physicians to ensure quality care and cost control in th health industry.

DA

Phase Two and the PBS Fee Study

The Pennsylvania Blue Shield study of physicians' fees, published in full in the August issue of PENNSYLVANIA MEDICINE, is an indication that physicians have been doing all along what is called for as the nation enters into Phase Two of wage and price controls, complete with a special watchdog committee for the "health services industry."

What the statistics reveal should be of interest to patients as well as to doctors. Essentially the study shows the PBS index of payments to physicians rose 12 percent in the two year period of 1969-70 over the base period of 1968. The PBS index of physicians' charges rose 16.2 percent in the same period, while the Consumers Price Index rose 13.8 percent and the all services component of that index rose 18.7 percent.

Obviously Pennsylvania physicians have been conservative in their approach to increasing charges for their serv ices, even in the face rising costs of the maintenance of practice.

This seems to be the message as Phase Two unfolds. Th nation is exhorted to practice moderation. The administra tive machinery for controls will be minimal. The nation' 360 local IRS offices should be able to answer questions. I you have paid employees or charge fees for a service, yo are asked to keep careful records on fee increases and raise in salaries— and to practice moderation.

If you reread the article on the Blue Shield study, pag 63, August PENNSYLVANIA MEDICINE, you will learn tha physicians in Commonwealth have been doing that righ along.

Physician, test thyself

It is an established dictum in the practice of medicine at diagnosis precedes treatment. The whole field of physician self-assessment follows that dictum. Through self-assessment tests, a doctor can check on his own educational needs before embarking on a program of continuing education. He can by self-testing determine where his deficiencies are, and be guided accordingly. Recently in PENNSYLVANIA MEDICINE, there appeared a list of available self assessment tests. The list was comprehensive, offering virtually every doctor an opportunity for an annual "medical alertness" check-up.

An innovative program being offered by the University of Illinois College of Medicine is now offering an unusual approach. Developed by private practitioners, it differs from all other such programs in that the physician tests himself on a monthly basis over a period of a year. The self-testing materials sent each month permit the doctor to test his clinical proficiency rather than his basic knowledge, and to guide him in "educational therapy." If such a plan appeals to you, write to the Continuing Education Section, University of Illinois College of Medicine, 835 S. Wolcott Ave., Chicago, Ill. 60612

Let George say it'

Society is the victim

"I am doing this for your own good," said the teacher with a sadistic smile, as she restricted her students' privileges. "It hurts me more than it does you," said the father, as he strapped his quivering offspring. "Your people sir, is a great beast," said, I think, Alexander Hamilton.

Individual citizens tend to distrust the citizenry as a whole. Each of us knows that we have enough moral stamina to resist degenerative urges. Unfortunately, many people are sure that the others are only waiting for the bars to be dropped to become lechers, gamblers, dope addicts, and worse.

In support of this widely held thesis we have had a whole assortment of laws to protect us against our lower natures. Our fellows have been paying fines and going to jail for playing ball on Sundays, consorting with ladies in hotel rooms, and making wagers on all sorts of events. In each case the damage done, if any, is to the involved person or persons. The danger to the public at large or to the innocent by-stander is minimal.

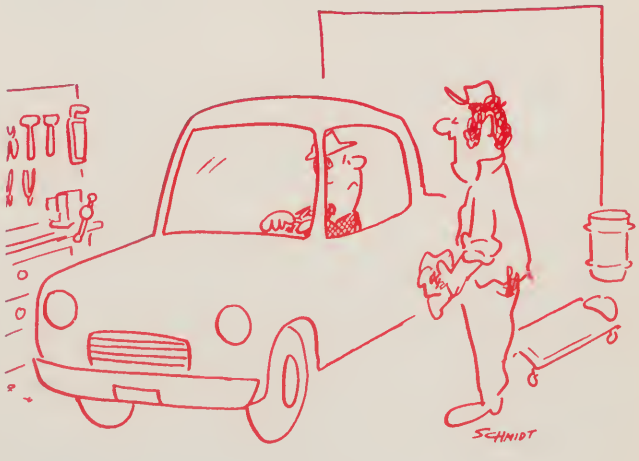
Our greatest concern today is with drug addiction. Policemen, psychologists, doctors, and chemists regularly explain the problem and what should be done to cope with its many facets. They seem to be agreed on only two points. The situation is bad and no one really knows what to do about it.

Judge Dandridge, of the Philadelphia Municipal Courts, recently suggested that heroin should be sold to addicts at ten cents a bag. He reasons that this will remove their need to resort to larceny and prostitution and greatly lower the crime rate. By removing the financial incentive (a million dollars worth of heroin would be devalued to less than ten thousand) organized crime would be discouraged from expansion in this field. Also, addicts would be assured of getting good quality drugs.

I believe that it will be a long time before any one in this country will take Judge Dandridge's recommendations seriously and implement them. I'm afraid that they are too sensible to be accepted. They will not be accepted because those two powerful interests: organized crime and the narcotics control officials will both oppose it to the last man. These groups will be supported by the less well organized but much greater force of public opinion which feels that such a step would open the door to decadence and degradation.

We don't really know what happens to drug addicts who have access to their drugs. We know what happens to alcoholics and we are willing to accept that hazard, but we all believe in our heart of hearts that free drugs would lead everybody to something like an old time opium hell. There would be so few non-addicts left behind that we would have trouble getting a table of bridge. I wish there was some way for someone to try out Judge Dandridge's proposal.

GAR



SHE'S ONLY GOT SIX MONTHS LEFT DOC... TAKE 'ER HOME AND LET HER ENJOY 'EM.

To the Editor:

Dr. Katharine Boucot Sturgis' article on the August, 1971 issue of Pennsylvania Medicine spotlights an urgent need: environmentalists need the testimony of physicians to combat air pollution.

Here, in Pittsburgh and Allegheny County, our citizens' organization GASP, Group Against Smog and Pollution, found that the testimony of physicians was one of the most effective weapons to bring about tough new clean air standards. But we need enforcement of the laws and continuous education of the public to pressure public officials and industrial polluters to this end.

We have quite a problem in Pittsburgh. This city was cited in 1970 by the National Air Pollution Control Administration as being one of the top ten dirtiest cities in the nation on two counts: sulfur dioxide emissions and air particulants.

Yet our citizens continue to be lulled by the euphoric complacency of believing: "But we cleaned up Pittsburgh twenty years ago. Back then, you couldn't see the sun at high noon." The man in the street does not understand that one does not see deadly sulfur dioxide fumes, or that fine dust particles which are not as visible as black soot, are, if anything, more harmful than the larger particles which blocked out the sun 20 years ago.

Prior to the 1969 clean air standard hearings in Allegheny County, there were very few, if any, contributions by local physicians with two or three outstanding exceptions.

Since then the situation has changed.

Under the leadership of Dr. Peter Safar, chairman of the Department of Anesthesiology at the University of Pittsburgh School of Medicine, an Environmental Committee was organized by the Allegheny County Medical Society. Eighty-five doctors now belong to GASP. And under the Chairmanship of Dr. Charles Watson, the GASP Medical Committee is now preparing projects and programs which will use the invaluable testimony and talents of our Allegheny County physicians.

Dr. Safar's testimony at a Variance Board hearing was instrumental in bringing about a recalcitrant Duquesne Light Company announcement that the corporation will invest twenty-five million dollars for pollution abatement equipment.

I would also like to cite the commendable actions of Dr. Murray Sachs, Pittsburgh respiratory disease specialist, who is appearing in an educational film GASP is now making for distribution to secondary school students in the county. Dr. Sachs' testimony in which he says "Pittsburgh polluters are playing Russian roulette with our citizens' lives" will be used in a public service TV spot.

Then there is Dr. Armas Kyllonen, thoracic surgeon in Braddock (one of the most heavily polluted areas in Allegheny County) who testified at a United States Steel Variance Board hearing. Dr. Kyllonen's testimony contributed to a landmark decision by the board which led to the curbing of pollution by one of the U.S. Steel plants, th Edgar Thompson installation.

I found it noteworthy that in the same issue of Pennsy vania Medicine, Dr. George A. Rowland ("A Time fo Unity") pointed up the difficulties facing the AMA, statin "Young doctors think the organization has its head buried in the past and refrain from joining." Also, Dr. J. Finto Speller's statement that "we say health can no longer be sep arated from social services."

Physicians who align themselves with the life-savin public service project of cleaning up our air will rebut thes two deficiencies. They can do this by helping educate th public...

There are data available in the criteria documents issue by the National Air Pollution Control Administration in ac cordance with the Air Quality Act of 1967.

The physician can read them, formulate his opinions o the basis of the evidence and preface his testimony with th statement "it is my opinion....".

In the words of Anderson (Canadian Med. Assoc. 97:802-806, 1967): "Though there are many serious limit tions to published research on the health hazards of a pollution, the *accumulated evidence from acute pollutio disasters, the urban effect as studied epidemiologically, an more detailed clinical, physiological and animal experi ments* CONFIRM THAT THIS HAZARD EXISTS."

Finally, may I submit Dr. Peter Safar's argument:

"We often hear from industry the argument that we d not really know what causes specific changes i measureable health related variables. This is an unfounde argument. Cigarettes definitely can cause cancer of th lung, although we do not know what specific substance i cigarettes does it. Likewise, air pollution has proven t harm a variable number of people. We know how to contr pollution and should insist that it is done, even if the speci ic substances and mechanisms involved are not understoo Pollution control technology has been developed. It is no mainly an economic and legal issue."

Speaking for GASP, and all fellow breathers, I woul submit one of the greatest services a physician can contri ute is to lend his valuable testimony to fighting air pollu tion.

We would all breath easier if he did.

(Mrs.) Esther Kitzes, Director of Public Informatio
Group Against Smog and Pollutio
Pittsburg

To the Editor:

Below find self explanatory-correspondence. I wa misquoted when I gave this paper in Dallas about 20 year ago and now it appears again.

It is self evident that I could not have made suc sweeping and derogatory remarks concerning expectant fa thers.

I am sure Dr. Brady has never had a busy obstetric practice for him to suggest home delivery on demand.

uld appreciate your making my stand on these matters ar with my fellow practitioners.

Mario A. Castallo, M.D., F.A.C.S.
Philadelphia

cerpt from the *Hartford Courant*, August 25, 1971, from olumn called *Personal Health*, by Fred Brady, M.D.

"A leading obstetrician once told the American Medical Association 'It just isn't true that men are not emotionally equipped to be with their wives at the moment of delivery. Dr. Mario A. Castallo of Jefferson Medical College, Philadelphia, said a man's place is in the delivery room at his wife's side, rather than pacing the waiting room.'"

illiam Brady, M.D.
The Hartford Courant
rtford, Conn. 06100

y dear Doctor Brady,

A classmate of mine saw the article on childbirth that ared in the Hartford Courant on August 25, 1971.

I do not quite agree with you that an expectant father be ade to witness his wife's childbirth under all circumnces.

There are certain men who can not and certain others o should not be in the delivery room when their wives ve their babies. This should be decided by the obstetrician in charge at the time of delivery.

Mario A. Castallo, M.D., F.A.C.S.

Katharine B. Sturgis, M.D.
349 Wister Road
Wynnewood, Pa. 19096

Dear Doctor Sturgis,

Your Special Report, "The Physician and Air Pollution" in the August issue of Pennsylvania Medicine is indeed pertinent to the health of all of us. I am sure I also speak for many other physicians when I say I greatly appreciate your studies, papers, actions and leadership. You are keeping the medical profession relevant to today.

I want to call attention to a problem in nomenclature in one reference you make. No doubt you think, as have others, that the name Jefferson Medical College has been replaced by that of Thomas Jefferson University. This is *not* true. Jefferson Medical College is the only name of that school of medicine. Dr. Williams, whom you cite, is a professor of Jefferson Medical College but not of the parent University. The corporate name Thomas Jefferson University was adopted in 1969 but the name of our medical school remains the same— Jefferson Medical College.

Elmer H. Funk, Jr., M.D., Past President
Alumni Association of Jefferson Medical College

Guest Editorial

Hospital Gamesmanship

As a hospital pathologist, and one who has long been interested in the ways medicine is practiced, eventually I have olved a certain ambivalence about hospital practice. On e one hand, it is to my advantage, as a chronic empirelilder in the laboratory, to have many laboratory tests orred. On the other, as an M.D. who tries to stay clinically ented, I am forced to wonder about some of the ways in hich I see the hospital used.

I have at last succumbed to the "German" bent for clasification and categorization, and have come up with the ur "P's" of medical practice. With apologies to all true literators, here they are:

1. "Pop-up" practice. This might also be called "plug-" practice. Here the doc plugs the patient into the hospital achine, and orders a continuing series of tests, x-rays, nctional studies, and the like, and waits for something to op-up abnormal. Then he says "Aha! that's what I thought was going to be," and proceeds to sit down and think bout the patient.

2. "Prove-it" practice. Here the doc has a much more ositive attitude, in a negative sense. He says to the Lab, or -ray, "Prove to me that the patient does not have this," nd they do it, and then, "Prove to me that the patient does ot have that," and they do that, and eventually he is forced o sit down and think about the patient.

3. "Put-off" practice. This is by far the most popular of the methods. Here the doc says "I've got to be Scientific about this thing, and this implies that I've got to be Systematic," and then he proceeds to check out the heart, and then the lungs, and then the liver, and then the kidneys, and then the spleen, and then when all else fails, he sits down and thinks about the patient. The lure of this method is almost irrestible, and its joys for the doc are matched only by its miseries for the patient. This type of practice naturally, and often leads to—

4. "Punt" practice. Here a gorgeous, mysterious, and multi-splendored interplay of emotional, intellectual, and financial factors reaches full flower. The factors interweave in a fashion that, dispite its bewildering complexity, is only too predictable. "I used to know all about that, but now I'm too busy to sit down and think about it." "I am quite sure it is this, but it would take a lot of time away from my practice to study up on it and treat the patient." "Old Joe knows just how to handle this, and I owe him a favor or two." "I know how to handle this, but it is risky, and if something goes wrong, I might get sued. I know the patient will have to travel fifty more miles, and it will cost the family three times as much, but that's the way things are." "This is a complicated bothersome job, and I can do a lot more good handling other things. So— I'll refer the patient!"

How does your hospital staff stack up on its "P" rating?

E.L. Abernathy, M.D.
Washington

Home care programs endorsed by PMS Board

The Board of Trustees of the Pennsylvania Medical Society has adopted this position statement on coordinated home health care which would permit patients ready to leave hospitals, but not able to care for all of their own needs, to return to their homes and receive the needed attention there.

The necessity for coordinated home care programs has reached a level of urgency that cannot be ignored by an enlightened and concerned people. The rapidly rising costs attendant to confinement in either a general hospital or a nursing home demand that, where possible, patients should be maintained at home. This program should be primarily reserved for patients whose health needs: (1) do not require hospitalization and cannot be met on an ambulatory or outpatient basis; (2) require a complex of medical, nursing, social and related services over an extended period of time; and (3) can feasibly be met by the program in a suitable physical and psychological home environment.

Depending on the needs of the patient, home care may require the services of many persons and organizations combining efforts as a team, directed by a physician, to provide the best possible health care and supportive services for the patient. Supervision by physicians is essential to the efficient and successful provision of home care services.

The physician should be aware of the home care services available in his community and the various methods by which his patients can pay for, or be assisted in paying for, such services. He should establish a plan of treatment for each patient he refers for home care and should review this plan periodically with home health personnel providing the care. The physician should insure that he receives regular reports, observations, and progress notes from the health personnel providing services. Special effort may be needed to maintain this communication when a patient is cared fo at home, because of the separation in time and distance be tween the different services and personnel involved.

A home health aid must be under the supervision of certified agency, either the Visiting Nurses Association or Registered Nurses Association. The home health aid should be restricted to performing personal care for the pa tient and to the administration of such medication that i routinely taken by the patient alone. He should be restricte as to the giving of hypodermics, enemas, and douches. Th home health aide program should be predicated on th proper orientation of basic home health care and the neces sity of direct supervision by a registered nurse whose initia orders come from the primary physician. For example, if visiting nurse feels she is not needed and that the patien could just as well be taken care of by a home health aide she should contact the physician in charge and get his per mission to make use of the home health aides.

Educational requirements for the training of a hom health aide should be specified in all programs and reviewe by an appropriate agency.

The homemaker service should be restricted to the per formance of strictly domestic duties in the patient's house hold and should not involve the care of the patient in an way. In any case, the homemaker should be under the direc tion of the primary physician and/or the visiting nurse.

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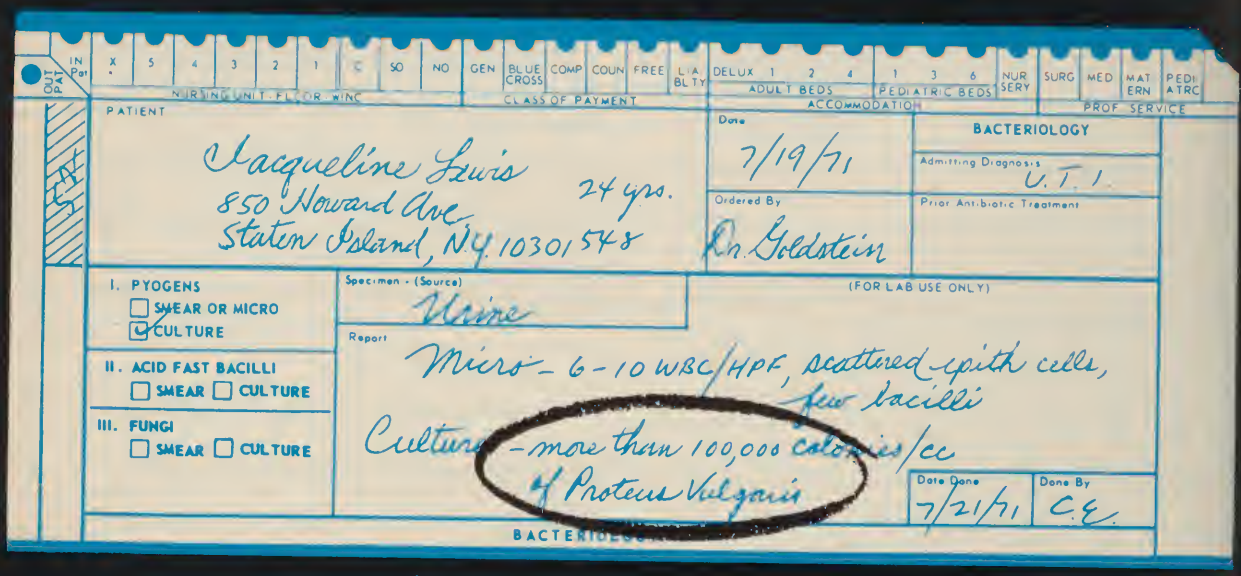

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PATIENT

Jacqueline Lewis 24 yrs.
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Date: 7/19/71

BACTERIOLOGY

Admitting Diagnosis: U.T.I.

Ordered By: Dr. Goldstein

Prior Antibiotic Treatment

I. PYOGENS
☐ SMEAR OR MICRO
☑ CULTURE

II. ACID FAST BACILLI
☐ SMEAR ☐ CULTURE

III. FUNGI
☐ SMEAR ☐ CULTURE

Specimen - (Source): Urine

(FOR LAB USE ONLY)

Report:
Micro - 6-10 WBC/HPF, scattered epith cells, few bacilli
Culture - more than 100,000 colonies/cc
of Proteus Vulgaris

Date Done: 7/21/71 | Done By: C.E.

BACTERIOLOGY

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(sterile disodium carbenicillin)

A serious urinary tract infection...
Proteus vulgaris, confirmed by pure culture. Fortunately, the strain proves sensitive to carbenicillin and the patient is not allergic to penicillins. The choice is clear: Pyopen.

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Bristol, Tennessee 37620

PRESCRIBING INFORMATION **Indications:** Primarily for treatment of infections due to susceptible strains of *Pseudomonas aeruginosa*, *Proteus* species (particularly indole-positive strains), and certain *Escherichia coli*. Clinical effectiveness has been demonstrated in the following infections when due to these organisms: Urinary tract infections; severe systemic infections and septicemia; acute and chronic respiratory infections (while clinical improvement has been shown, bacteriologic cures cannot be expected in patients with chronic respiratory disease and cystic fibrosis); soft tissue infections. Although PYOPEN (disodium carbenicillin) is indicated primarily in Gram-negative infections, its activity against Gram-positive organisms should be kept in mind when both Gram-positive and Gram-negative organisms are isolated (see Actions). **Note:** During therapy, sensitivity testing should be repeated frequently to detect the possible emergence of resistant organisms. **Actions:** Organisms found to be susceptible *in vitro* include: Gram-Negative Organisms-*Ps. aeruginosa*, *Proteus mirabilis*, *Pr. morganii*, *Pr. rettgeri*, *Pr. vulgaris*, *E. coli*, *Enterobacter* species, *Salmonella* species, *Hemophilus influenzae*, and *Neisseria* species. Gram-Positive Organisms-*Staphylococcus aureus* (nonpenicillinase-producing), *Staph. albus*, *Diplococcus pneumoniae*, Beta-hemolytic streptococci, and *Streptococcus faecalis*. Some newly emerging pathogenic strains of *Herellea*, *Mima*, *Citrobacter*, and *Serratia* have also shown *in vitro* susceptibility. Not stable in the presence of penicillinase. *Klebsiella* species are resistant. Some strains of *Pseudomonas* have developed resistance fairly rapidly. **Contraindications:** Known penicillin allergy. **Warnings:** Serious and occasional fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, appropriate therapy should be instituted and discontinuance of disodium carbenicillin therapy considered, unless the infection is life threatening and only amenable to disodium carbenicillin therapy. The usual agents (antihistamines, pressor amines, and corticosteroids) should be readily available. **Usage in Pregnancy:** Safety for use in pregnancy has not been established. **Precautions:** As with any other potent agent, it is advisable to check periodically for organ-system dysfunction, including renal, hepatic, and hematopoietic systems, during prolonged therapy. Emergence of resistant organisms, such as *Klebsiella* species and *Serratia* species, which may cause superinfection, should be kept in mind. Each gram contains 4.7 mEq sodium; in patients where sodium restriction is necessary, such as cardiac patients, periodic electrolyte determinations and monitoring of cardiac status should be made. Observe patients with renal impairment for bleeding manifestations and adhere strictly to dosage recommendations. If bleeding manifestations appear, discontinue antibiotic and institute appropriate therapy. As with any penicillin preparation, the possibility of an allergic response, including anaphylaxis, may occur, particularly in a hypersensitive individual. **Administration:** Intramuscular injections should be made well within the body of a relatively large muscle (not into the lower and mid-third of the upper arm), and aspiration is necessary to help avoid inadvertent injection into a blood vessel. May be given by either intravenous injection or intravenous infusion. After reconstitution with Sterile Water for Injection unused portions should be discarded after 24 hours if stored at room temperature, or after 72 hours if refrigerated. **Adverse Reactions:** *Hypersensitivity Reactions*—Skin rashes, eosinophilia, pruritus, urticaria, drug fever, and anaphylactic reactions. *Gastrointestinal Disturbances*—Nausea. *Hemic and Lymphatic Systems*—Hemolytic anemia, thrombocytopenia, leukopenia, neutropenia, in uremic patients receiving high doses (24 gm/day), hemorrhagic manifestations associated with abnormalities of coagulation tests, such as clotting and prothrombin time. *Hepatic and Renal Studies*—SGOT and SGPT elevations have been observed, particularly in children. To date, no clinical manifestations of renal disorders have been demonstrated. *Central Nervous System*—Convulsions or neuromuscular irritability could occur with excessively high serum levels. *Local Reactions*—Pain at the site of injection, sometimes accompanied by induration. Vein Irritation and Thrombophlebitis—particularly when undiluted solution is injected directly into the vein. **How Supplied:** Available in 1 Gm. and 5 Gm. vials.
Before prescribing or administering, see package circular or PDR.

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A family doctor looks at new developments in the pharmaceutical industry. And he speculates on the future.

When I look back at some of my old records, I'm constantly reminded of the changes that have come about in medicine just during the past twenty-five years. Some of the diseases I treated and prayed over in the '40's are found mostly in medical history books now.

Thanks to drug research and development, we've made substantial gains in the control of cardiovascular disease, diabetes, malaria, mental illness, strep and staph infections, meningitis and a long list of ailments. It seems like only yesterday when a diagnosis of pneumonia was almost the kiss of death. Now, with modern medical techniques and drug therapy, we can offer some real help.

My records on polio, influenza and measles show an unbelievable trend for the better. New vaccines have reduced the toll of these age-old threats dramatically. And I see patients in pain from crippling arthritis helped with new medicinals unknown just a few years ago.

I hear questions about the three billion or so dollars spent by the drug industry in research during the past ten years . . . working on new and better drug products. It does seem like quite a bit of money to spend, and I realize some of it goes into dead ends. That's the problem with research, any research . . . you often don't know where you're going until you get there. I want all the tools I can get to help my patients. I want more drugs and more effective drugs. If they mean less pain, longer lives and more productive careers for those I treat . . . well, that's what really counts.

Another point of view . . . Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.

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Indications: Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. *Contraindications:* Hypersensitivity to any of the components. *Precautions:* As with all phenacetin-containing products, excessive or prolonged use should be avoided. *Side effects:* Side effects are uncommon, although nausea, constipation and drowsiness may occur. *Dosage:* Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.

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'head clear upon arising'

For upper respiratory allergies and infections including the common cold, Dimetapp Extentabs® effectively relieve the stuffiness, drip and congestion all night and all day long on just one Extentab every 12 hours. For most patients drowsiness or overstimulation is unlikely.

prescribing information appears on next page

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Dimetapp® Extentabs

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NDICATIONS: Dimetapp Extentabs are ndicated for symptomatic relief of aller-ic manifestations of upper respiratory lnesses, such as the common cold, sea-onal allergies, sinusitis, rhinitis, con-unctivitis and otitis. In these cases it uickly reduces inflammatory edema, asal congestion and excessive upper espiratory secretions, thereby affording elief from nasal stuffiness and postnasal lrip.

CONTRAINDICATIONS: Hypersensitivity o antihistamines of the same chemical lass. Dimetapp Extentabs are contrain-licated during pregnancy and in children nder 12 years of age. Because of its dry-ng and thickening effect on the lower espiratory secretions, Dimetapp is not ecommended in the treatment of bron-hial asthma. Also, Dimetapp Extentabs re contraindicated in concurrent MAO nhibitor therapy.

VARNINGS: *Use in children:* In infants nd children particularly, antihistamines n overdosage may produce convulsions nd death.

PRECAUTIONS: Administer with care to atients with cardiac or peripheral vascu-ar diseases or hypertension. Until the atient's response has been determined, e should be cautioned against engaging n operations requiring alertness such as lriving an automobile, operating ma-hinery, etc. Patients receiving antihista-nines should be warned against possible dditive effects with CNS depressants uch as alcohol, hypnotics, sedatives, ranquilizers, etc.

ADVERSE REACTIONS: Adverse reac-ions to Dimetapp Extentabs may include ypersensitivity reactions such as rash, rticaria, leukopenia, agranulocytosis nd thrombocytopenia; drowsiness, lassi-ude, giddiness, dryness of the mucous nembranes, tightness of the chest, thick-ening of bronchial secretions, urinary requency and dysuria, palpitation, hypo-ension/hypertension, headache, faint-ness, dizziness, tinnitus, incoordination, isual disturbances, mydriasis, CNS-lepressant and (less often) stimulant effect, anorexia, nausea, vomiting, diar-hea, constipation, and epigastric dis-ress.

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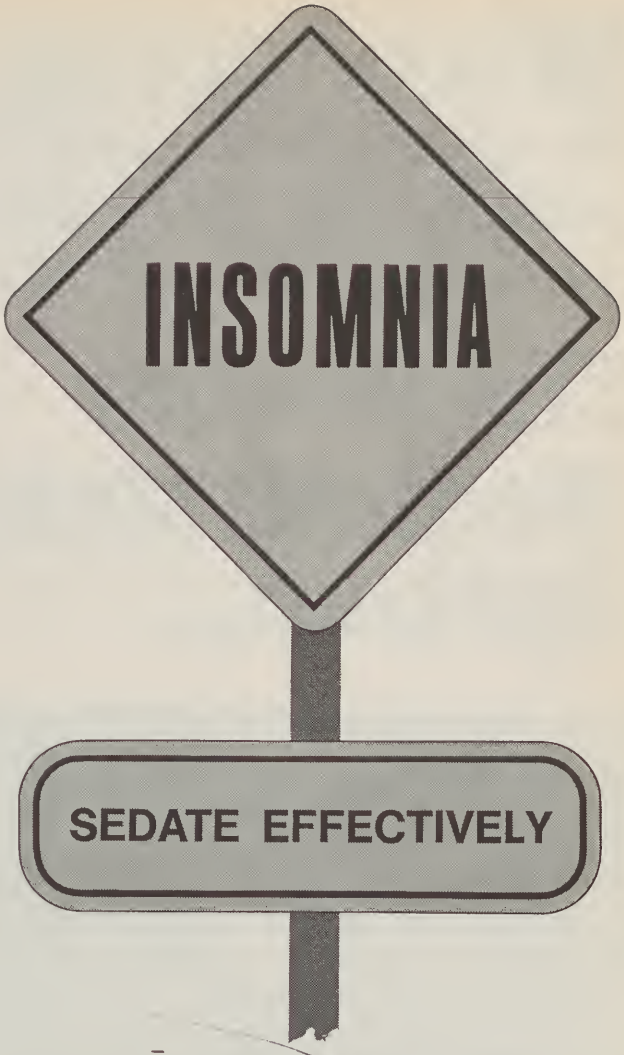

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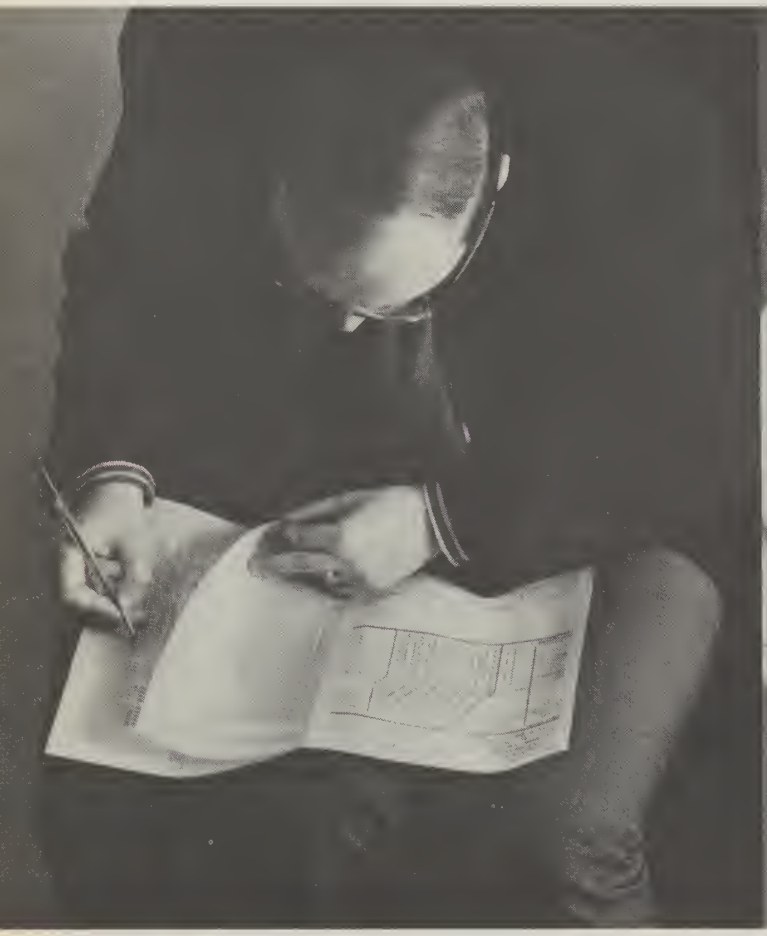

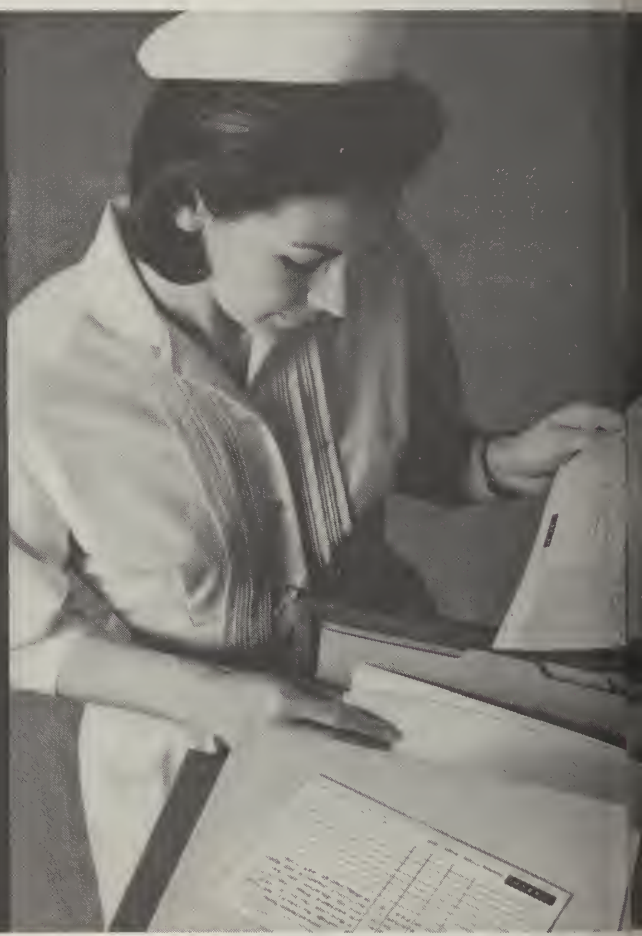

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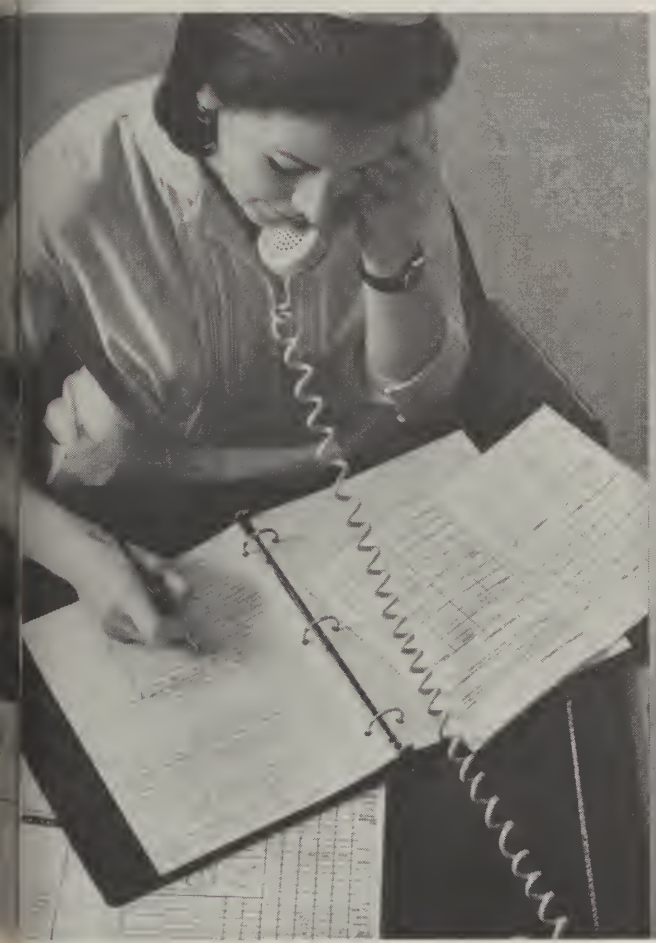

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DISCOMFORT ON STANDING

WHEN ASSOCIATED WITH IMPAIRED PERIPHERAL CIRCULATION

ALSO PROVIDES CONCOMITANT ADMINISTRATION OF THE LISTED VITAMINS.

SIDE EFFECTS: Flushing with heat and itching, in some cases followed by sweating, nausea and abdominal cramps. This reaction is usually transient. Nausea caused by high acidity can be relieved by non-absorbable antacid. **REFERENCES: 1.** *Parsons, W.B., Jr. — Interview Med. Trib. Nov. 28-29, 1964.* **2.** *Cohen, D., JAMA, Aug. 6, 1960, Vol. 173, No. 14, P. 1563.*

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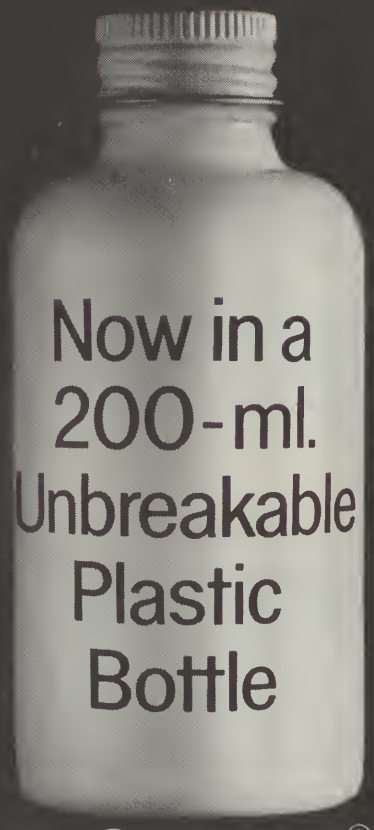

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Indications and Interpretation of Newer Tests of Thyroid Function

P. JOHN PEGG, M.D.

Philadelphia

THE LAST THIRTY YEARS has seen the introduction of a large number of new tests of thyroid function with little of the old being discarded. This has led to a situation where we are in danger of becoming swamped by a plethora of tests, the indications for which may be far from clear and the interpretation of which may be far from obvious.

It is important to realize that the procedures presently available measure essentially different aspects of thyroid function. The basal metabolic rate and ankle-jerk relaxation time measure the peripheral effects of thyroid hormone, but these are not very reliable diagnostic procedures. The radioiodine uptake tests provide an indirect measure of the rate of hormone formation, but results can be misleading particularly where there is an increased body iodine pool. Thirdly, the level of thyroid hormone in the blood may be measured and this is the topic of discussion in this paper.

Serum Tests of Thyroid Function

For many years, the protein bound iodine (PBI) has been the mainstay of thyroid diagnosis and remains the laboratory yardstick by which newer tests are measured. It has a clinical diagnostic accuracy in thyrotoxicosis in the region of 90%, but somewhat lower in hypothyroidism. However, a very large number of drugs, most con-

	Thyroxine (5 - 13 ug/100 ml)	Resin Uptake Ratio (0.85 - 1.15)	Free Thyroxine Index (4.5 - 12.0)	
Euthyroid	10.8	0.90	9.7	
	8.3	1.07	8.9	
	12.7	0.73	9.3	
	10.6	0.97	10.3	
	8.0	0.95	7.6	
	6.6	0.94	6.2	
	5.7	1.03	5.9	
Thyrotoxicosis	20.7	1.56	32.3	
	19.0	1.37	26.0	
	13.4	1.22	16.3	
	25.8	1.50	38.7	
Hypothyroidism	2.3	0.79	1.8	
	1.7	0.58	1.0	
	0.6	0.73	0.4	
	2.6	0.85	2.2	
Oral Contraceptives or Pregnant	13.6	0.77	10.5	
	13.5	0.65	8.8	
	12.1	0.63	7.6	
	12.1	0.60	7.3	
	13.9	0.49	6.8	(P)
	22.5	0.73	16.4	(P)
	12.7	0.73	9.3	(P)
	6.3	0.58	3.6	

Normal Values in parentheses, P — Pregnant

taining iodine in one form or another, are known to interfere with PBI determinations, so a technique which avoids this contamination immediately becomes attractive. The butanol extractable iodine (BEI) had a limited vogue, but showed very little advantage over the PBI. Now two methods are replacing the PBI, T_4 by column and T_4 by competitive protein binding, commonly referred to as "Murphy-Pattee" after the originators of one of the techniques used.

T_4 by column is basically a PBI technique in that iodine is measured, but a preliminary column chromatographic separation increases the specificity by removing a large number of contaminants. However, some iodine contamination may remain, notably by certain X-ray contrast media, and iodine determination, despite automation, still has its problems. For these reasons we have adopted the competitive protein binding technique of Murphy.

One of the most exciting advances in clinical laboratory work over the past decade has been the development of competitive binding assay techniques. Radioimmunoassay is an example of this approach and is now being used to measure many of the polypeptide hormones. In the competitive protein binding assay for thyroxine (T_4), competition takes place between radioactively labelled and unlabelled thyroxine for binding sites on thyroxine binding globulin. There is no interference in this technique from any iodine containing compounds, hence a marked increase in specificity. Our normal range for serum thyroxine is 5 to 13 μg/100 ml, corrected for recovery. It is important to remember that this is thyroxine and not thyroxine iodine, which would be 65% of the values quoted above.

Serum thyroxine estimations show a high degree of diagnostic accuracy, exceeding 90% in thyrotoxicosis, and represent a considerable improvement on PBI for the diagnosis of hypothyroidism. However, changes in the circulating thyroid binding proteins will also result in T_4 changes which are not in keeping with the patient's true thyroidal status, and it is here that the next group of tests, the resin uptake tests, help us to elucidate the problem.

The Resin Uptake Tests are commonly referred to as "T_3-tests". This is unfortunate, since they do not measure T_3, that is, triiodothyronine. They are called T_3 tests because radioactive T_3 is used to estimate the number of binding sites unoccupied by T_4 on the patient's thyroid binding globulin, or TBG. Normally TBG is about one third saturated with T_4, but in thyrotoxicosis, with increasing circulating levels of T_4, the number of free binding sites will decrease. Radioactive T_3 added to the patient's serum will occupy these sites but to a lesser extent than normal. A resin is used to "mop up" the T_3 which has not been bound by the TBG and it can be seen that in thyrotoxicosis the resin will take up more T_3 than normal. The converse will apply in hypothyroidism. The resin uptake is commonly expressed as a percentage of the total radio-activity added to the serum sample, normally around 30%. Various other ways of expressing the result have been used. We express our resin uptake result as the ratio to a pooled control serum. Thus, if the T_3 resin uptake of the unknown and pool were both 30%, the resultant *resin uptake ratio* (RUR) would be 1.0. Our normal range is 0.85 - 1.15 with high values tending to occur in thyrotoxicosis and low values in hypothyroidism. The resin uptake ratio, by itself, does not give any more information on diagnosis than does the T_4, in fact the diagnostic accuracy is less. The great usefulness comes from taking the two tests in combination.

It was mentioned earlier that T_4 results may be misleading because of changes in the capacity of circulating thyroxine binding globulin (TBG). Resin uptake tests will also be misleading, *but in the opposite direction*. The table lists results obtained for T_4 and RUR in a variety of conditions. The Free Thyroxine Index in the third column is obtained by multiplying the figures in the first two columns. The free thyroxine index has been so called because it shows a reasonably good correlation with measured free thyroxine levels, which in turn usually correlate well with the metabolic state. Our normal range for FTI is 4.5 to 12.0, i.e. very similar to the serum T_4 levels. The third result in the euthyroid group shows a high normal T_4, 12.7 μg/100 ml and a low resin uptake ratio 0.73. A low uptake ratio can mean one of two things, either the subject has a normal TBG capacity and

ot much T_4, or he has an increased BG capacity. We know from the T_4 sult that he has plenty of circulating $_4$, so there may be an increase in yroxine binding capacity. Either sult, taken by itself, could be misading; the free thyroxine index howver, is well within the normal range nd indicates the true thyroidal status.

In thyrotoxicosis results for T_4 and UR move in the same direction, ence the product of the two tests mphasizes the difference from ormal. A similar effect is shown in e hypothyroid group.

There are several interesting exmples in the group of subjects who ere either pregnant or taking oral ntraceptives, both situations in hich there is a considerable increase TBG binding capacity. Most of ose taking oral contraceptives had gh or boarderline high T_4 values, but ith low resin uptake results the free yroxine index fell into the normal nge. One pregnant patient has a very gh T_4, 22.5 μg/100 ml, with a resin take result, 0.73, not nearly as low some others. The resultant free yroxine index, 16.4, suggested thyroxicosis, which was indeed what the atient had. The last subject in this oup was a patient taking oral conaceptives who had symptoms suggesve of hypothyroidism. The T_4 was in e normal range, 6.3 μg/100 ml, but is, coupled with a very low RUR ave a free thyroxine index in the ypothyroid range.

In some resin uptake methods the pernatant rather then the resin is unted, i.e. a count of the proteinund labeled T_3 is made. In this situaon high supernatant counts would inicate an increased number of availble TBG binding sites. The Thyroid inding Index uses this approach; the ormal range is roughly the same as e resin uptake ratio, but low values ill now suggest hyperthyroidism. ther T_3 uptake tests may use coated harcoal rather than resin to take up e unbound T_3 but the principle emains the same. There are now a umber of kits available for perorming these tests and it is important establish a normal range under the onditions of use and to understand hat the range means.

The measurement of free thyroxine a difficult procedure because of the very small quantities measured and has not become a routine practice. While free thyroxine levels do correlate reasonably well with thyroid status there is a considerable overlap, particularly in the euthyroid "sick" who tend to have raised free T_4 levels. The total T_4 taken alone has a greater diagnostic reliability, so the main usefulness of free T_4 measurements is in those patients with an alteration in binding proteins. We have already seen how a much simpler test, the resin uptake ratio, can correct for those changes.

Thyroid Autoantibodies

Three thyroidal antigen/antibody systems have been described, but tests currently used clinically are for thyroglobulin antibody. A commercially available kit measures these antibodies by a latex aggregation technique and will give positive results in about 75 percent of cases of severe Hashimoto's disease. A considerably more sensitive technique employs tanned red cell (TRC) agglutination. This will give positive results in many asymptomatic patients with focal thyroiditis. The TRC agglutination test is commonly positive in primary hypothyroidism, but far less commonly in those patients with myxedema secondary to pituitary failure.

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Also, it may be positive in thyrotoxicosis and in patients who have exophthalmos but are clinically euthyroid. In order to make a definitive diagnosis in the presence of thyroid auto-antibodies it may be necessary to do other confirmatory tests.

Assessment of Response to Treatment

The assessment of response to treatment in thyroid disease, other than by clinical examination, remains unsatisfactory. Giving exclusively T_3 in hypothyroidism will result in a low serum T_4 value when the patient is euthyroid, which is not very helpful in assessing progress. Conversely, giving exclusively thyroxine, results in a high T_4. The use of a T_4/T_3 drug combination in the ratio of 3:1 will maintain the serum T_4 level in the normal range and this can be used to assess response to treatment. If the patient omits to take the tablets, the T_4 level will fall fairly rapidly and this can be readily recognized.

The Future

Looking into the 1970's I think that the major step forward will be the ready availability of methods to measure triiodothyronine (T_3) by radioimmunoassay. The normal serum concentration of T_3 is only about 0.2 μg/100 ml, but it is being increasingly appreciated that the major metabolic effect of thyroid hormone is due to T_3. A number of cases of thyrotoxicosis with normal T_4 levels have now been described. All so far have been found to have markedly increased serum T_3 levels of between 0.4 and 1.5 μg/100 ml, and hence a new term, T_3 thyrotoxicosis.

Conclusions

The refinement of other more specialized techniques continues and we can expect that our diagnostic capabilities with the borderline case will improve. Until that time, and for the great majority of cases, the measurement of T_4 and resin uptake in combination offer the greatest diagnostic accuracy. However, there will still be situations where "endogenous bioassay" (Dr. Jack Oppenheimer) may be the only way to arrive at a correct diagnosis. □

Assessing the Quality of Medical Care

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This paper was delivered at the 1970 PMS Scientific Assembly

'By whatever system the quality of care is assessed, it should be understood that the information obtained is useful only as it may relate to planning remedial actions where deficiencies are identified.'

THE OBJECTIVE of assessing the quality of medical care is to provide information concerning patient care as well as to identify those special patient care problems whose solution might be facilitated through the development of continuing medical educational programs. There are still many hospitals, however, which do not integrate their programs in continuing medical education with information concerning the quality of patient care.[1] Nevertheless, when the hospital's educational program is seen in relation to patient care needs, it is possible to design a curriculum for correcting the educational deficiencies of physicians. Evaluation of the program can then be accomplished by judging the quality of care rendered to patients. Unless this is done, one will not be able to claim that the physician's knowledge, as measured by examinations, is translated into performance, namely the imporvement of the patient's health— the ultimate goal of medical education.

Techniques for Assessing the Quality of Medical Care

Historically, monitoring of patient care has been done indirectly by promoting the quality of the educational programs of the medical school, internship, and residency. Only in the recent past has a commitment been made in the direct assessment of patient care by peer review.

The issues to be evaluated by review committee are many an complex. Decisions will revolve on: 1 the indications for admission; 2) th diagnostic and therapeutic proces and 3) plans for post-hospital care. Th methods used to deal with these issue will depend on the problems to b solved.

In general, evaluation has been re stricted to correct abuses in admis sions, length of stay, and types of sur gical procedures. In many cases onl flagrant violations will receive atten tion and this of a disciplinary nature.

The reports received from The Hos pital Utilization Project and the Pro fessional Activities Study are usefu since they provide monthly listings o

sease, length of stay, number of consultations, types of laboratory tests, nd a comparison with other hospitals. Vide variations among institutions are ot necessarily indicative of good or oor practices but are clues which eed further explanation. For example, formation that the length of stay for atients with pneumococcal pneumoia at Hospital X is seven days and at ospital Y eleven days cannot be used) indict or praise either institution nless one has the following data: 1) ie accuracy of the diagnosis; 2) the inical status of the patient at the time f admission; 3) the mortality; and) the long term morbidity. Even if ie diagnosis were correct at both institutions the patients admitted to the istitution with a shorter hospital stay iay be at a higher risk because of the iability of the staff to cope with emerencies and, in addition, those who about the quality of care which has been given with regard to an individual case. The check list may establish that some medical procedure was or was not performed; it will show that there was or was not recorded some particular indication for a certain procedure; and it will indicate what the nature of the outcome was. It will not tell whether it was proper to perform the given procedure or whether the procedure provided optimal results.

Physicians, because of their varied training and clinical experience, tend to evaluate medical care differently. Therefore, it is necessary to arrive at a consensus on the medical standards to be required in the audit. These standards should also be reviewed by external experts. Efforts should be made to avoid setting standards which are parochial in nature or identified with the interests of a minority unable to justify its arguments scientifically.

'Only if there is a close relation between the assessment of the quality of medical care in a hospital and its educational program, is it possible for educational activities to be designed to overcome the identified deficits.'

rvive may not be investigated for the mplications of pneumonia and for sociated diseases. The latter defiencies will lead to long term disabiliand repeated hospitalizations.

Establishing Standards of Medical Care

The effectiveness of chart review is nited by several factors. Foremost nong these is the lack of uniformity ith regard to the ways in which different physicians evaluate charts. It is sirable, therefore, for physicians to ake a check list of items to consider ior to conducting a review. Reference ay be made to the check lists prepared / Payne at the University of Michian.[2]

The check list serves to provide an formation base which will be uniorm for charts under review. It does ot guarantee, however, that all of the embers of a medical audit will agree

Criteria of Assessment

For assessment in any field to be valid, certain basic conditions regarding the kind of measurements to be used must be met. The measurements must be both reliable and valid. Determination of reliability and validity is complex, but the basic concepts are easily understood. Measurements are reliable if the same results are consistently obtained while measuring the same things under the same circumstances. Measurements are valid if they measure what they are supposed to measure. A reliable measure for weight would be an invalid measure for height or speed. Validity presupposes reliability; therefore, attention is necessarily directed first at reliability, and only when this is assured is validity investigated.

Translated into the context of evaluating the quality of medical care patients receive, it would appear that there exist reasonably adequate measures, at least from the point of view of reliability. Different physicians looking at the same record with the same check list and the same criteria of care to guide them will make similar judgments about the quality of care. In addition, it is possible to pass over much of the routine of chart review to lay personnel or even to computers with no loss of reliability of measurement.

The problem of chart review, however, is the same as the problem of written examinations given in medical school or for certification: although it is relatively easy to get highly reliable measures, their validity is uncertain. Medical charts often bear little relation to the patients they are supposed to describe. Most likely they suffer from serious errors of omission. Because information is omitted, it is not possible to determine whether or not it was important and might have influenced the judgment which is made about the quality of care the patient has received. Without certain information, the adequacy of the diagnosis upon which all else rests is not certain. In addition, the relative contributions of interns, residents, and attending physicians are frequently compounded. It may also be difficult to know what information was or was not available to a physician at the time he gave a certain medical order. Information may be available to the physician about a patient in his office files and not on the hospital chart. Errors of omission may also be related to errors of commission. The appropriateness of a given treatment may depend upon conditions, information about which has been omitted. All of these limitations present serious obstacles to effective assessment of patient care utilizing

the medical chart as the instrument of evaluation.

In response to the problems of assessing the quality of medical care, Gonnella, et al, have proposed an alternative approach.[3] They have proposed, in substance, that errors of omission be identified by a careful prescreening of patients for health needs in specific areas. This survey should be done independently from the patient's personal physician. This approach has demonstrated that there are in fact serious omissions of information in patient records, and that in many cases the patient had a disorder which could have been identified and could have been treated had additional information been obtained by the physician. The presence of such information in the patient's record would lead to quite a different conclusion about the quality of care received. The absence of this additional information greatly reduces the probability of the true patient care needs being identified.

Planning

By whatever system the quality of care is assessed, it should be understood that the information obtained is useful only as it may relate to planning remedial actions where deficiencies are identified. In some cases where medical audit has revealed deficiencies, these have been corrected through the purchase of new laboratory equipment or other facilities for the hospital. In other cases hospital procedures may be changed. For example, tumor registry numbers are entered onto hospital charts so that follow-up information on patients with cancer may be more easily obtained. However, only if there is a close relation between the assessment of the quality of medical care in a hospital and its educational program, is it possible for educational activities to be designed to overcome the identified deficits. This relationship will provide a rational system for setting priorities in identifying deficiencies as for example, by utilizing the guidelines developed by Williamson, et al.[4]

Where the deficits which have been uncovered involve apparent gaps in physicians' knowledge, the use of a suitable examination covering the information under discussion may permit better identification of those physicians who may be especially knowledgeable and who may then serve as the hospital's own internal faculty in giving instruction to the rest who need it, or they may be excused from whatever educational program may be planned. When an educational program is prefaced by a pre-test and ended with a post-test, the changes in physician knowledge may then be correlated with changes in physician performance, however that is measured. The possibility also arises of physicians having knowledge as measured by an examination and of not using it in their actual practice of medicine.[3] Should this be the case, alternate remedial programs are required. In extreme situations this may involve limiting physicians' privileges.

Prediction

Recognizing that any kind of medical audit, whether it is based upon the review of medical charts or upon independent evaluation of patients, is time consuming and therefore expensive, the possibility is held out for future development of methods for identifying deficits in the quality of medical care by simulating the physician/patient relation. Efforts have been expanded in this direction already by the design of "Patient Management Problems".[5,6,7] By a simple erasure technique, using paper and pencil, a physician may "treat a patient" using cues provided in writing. In a "cueless" adaptation of this, digital computers are being programmed to simulate patient care. The physician may "interrogate his patient" in order to obtain a history, may be given certain laboratory findings, may request consultations, give medical orders, and so forth, until the patient is cured or dies. Feedback to the physician is quick, and he may recognize his own mistakes as he makes them. Although there are many technical problems involved in this approach, it combines numerous advantages. Education and evaluation are simultaneous.

The simulated patient approach should provide a closer parallel to actual patient management than any of the other testing techniques. However, until there is better understanding of true patient needs, based upon actual observation and utilizing optimal criteria established by recognized authorities in the field, the validity of this approach must also be uncertain. As this is improved, the simulated patient technique will become of profound importance not only for continuing medical education but in the education of medical students, and, perhaps, some day in their selection.

Conclusion

Perhaps the major practical obstacle to more active programs of assessing the quality of medical care is a lack of commitment on the part of physicians and of hospitals. It would appear that much energy which might be directed towards this is presently being directed towards other activities, as, for example, the development of recertification examinations for physicians. If some of the effort which is put into the construction of such examinations were to be put into the determination of patient care needs, and if appropriate educational programs were then organized to meet these needs, there is little question that the objectives of continuing medical education would more likely be met. □

Dr. Gonnella is associate professor of medicine and associate dean and director of the Office of Medical Education and Mr. Zeleznik is associate director of the Office of Medical Education at Jefferson Medical College of Thomas Jefferson University.

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New President Sets Goals

GEORGE P. ROSEMOND, M.D.

PMS President

I am honored and pleased to come the 122nd President of the nnsylvania Medical Society. I have ld office in other organizations, but e Pennsylvania Medical Society is e most important medical group by r in this State. Therefore, it has my imary interest and I hope has yours.

Some have questioned the need and irpose of a society such as this. I say you that the need was never greater id the purpose never clearer than it is day in this era of rapid change. This ociety is needed because it furnishes e only umbrella under which all hysicians, regardless of specialty and gardless of race, color or creed, can perate on an equal basis. It should ot and cannot take the place of ecialty societies or special interest ganizations. However, it is supporve rather than antagonistic to such letimate organizations.

The purpose of the Pennsylvania ledical Society is to achieve for medial practitioners the best possible conitions consistent with what is best for he public.

All matters directly or indirectly elated to health should be within our ealm of interest. This is a broad base om which to operate and it encomasses not only medical but social ills s well. Obviously, because it would be oo laborious to include all pertinent natters, a few points will be mphasized.

Our interest is health care, and it ehooves us to lead the thinking in this ield. In the past we have been accused of reacting negatively in the wake of ublic opinion. I doubt that such a harge can be proven regarding our Society at this time.

One of the most progressive steps aken for public good is the esablishment of the Pennsylvania Medical Care Foundation under dynamic nd inspirational leadership. This Foundation, although still in the stage of organization, epitomizes our willngness to accept the responsibility for he delivery of good health care at reasonable cost. It also permits us to work in partnership with all interested in health care, including the general public, private enterprise, labor unions, insurance carriers and government. This is your project and its success can be assured by your understanding participation. **I recommend approval of the Supplemental Report of the Council on Medical Service relating to the Medical Care Foundation.**

The Pennsylvania Medical Continuing Education Institute and the Society's continuing education membership requirements are progressive steps and deserve your continued support. I recommend approval of the Institute and the continuing education requirements for membership in the Society.

Because the Society is the medical umbrella, so to speak, it has a unique communication opportunity. Communication should be our strength, but it may be our greatest weakness. The Pennsylvania Medical Society is interested in the welfare of its membership and the welfare of the public. We have either done our communication job ineffectively or we have been misunderstood. Possibly a little of both is nearer the truth.

Communication is often difficult, but efforts in this direction must be continually re-evaluated so that the line of transmission may be kept open. Among communicants are:

LOCAL UNITS, the county medical societies which are the foundation of our strength.

DOCTORS OF OSTEOPATHY with whom we share many mutual problems and goals.

SPECIALTY ORGANIZATIONS. We are the society of specialty groups as well as the society of individuals.

SPECIAL INTEREST MEDICAL ORGANIZATIONS, such as the Keystone Medical Society.

GOVERNMENT on the local, state and national levels.

THE PRESS. In my opinion, willingness to communicate means a better informed and more accurate press. We do not fear truth.

DR. ROSEMOND

THE LEGAL PROFESSION. One of our prime disagreements with lawyers is their insistence on the contingency fee. I note that Mr. Henry T. Reath, Chairman of the Lawyers' "White Hat" Committee of Philadelphia, defends this as he properly goes about ferreting out corruption. It could be that this contingency fee is proper if rightly employed. **I urge our Commission on Forensic Medicine, together with law representatives, to consider investigating misuse of the contingency fee instead of its elimination.** Lines of communication must be kept open with the legal profession. In spite of philosophic differences, we have much in common.

MEDICAL SCHOOLS. Continued dialogue is needed in this area if mutual confidence and understanding are to be maintained.

MEDICAL STUDENTS. I will comment on this later.

ALLIED HEALTH PROFESSIONS. Much spade work is necessary in this rapidly expanding area.

LABOR UNIONS and also such other organizations that have health care programs.

Although understanding rapport with all of the groups listed may be impossible due to certain basic philo-

sophical differences, our efforts must continue.

County and State Society district censors, in my opinion, should do more than investigate only when specific complaints are submitted. Inquiry into breeches of ethics and breeches of confidence should be made in order to develop evidence for censor, as censorship should be meaningful, and this I recommend.

Rapport with our State Board of Medical Education and Licensure can be made so stable that temporary or permanent suspension of license will become more than an idle threat. Factual protection of the reputation of our profession must be maintained.

The Pennsylvania Medical Society has a generation gap. Partial correction of this is being accomplished by the admission of intern and resident physicians as active members. Now we must turn our attention again to the medical student, as, in my opinion, it will not suffice to talk at them through the Student American Medical Association. Communication in general leaves something to be desired. Our ruling bodies are made up mainly of "old" men such as I. Positive consideration must be given to a technique fashioned so that medical students can be included as active members. **I recommend favorable consideration by this House and changes in the Bylaws that will make it possible to admit third and fourth year medical students to active County and State Society membership.**

Acceptance of responsibility by increased activity in the planning process to protect our environment is imperative. Our Commission on Environmental Health has an important role to play. Each of us should again look at the present situation and assume some leadership in the fight against air, water, land and noise pollution.

We should continue to expand our efforts in the emergency medical care area as exemplified in the so-called "White Paper" developed by the Commission on Emergency Medical Services. If you have not read this paper (*Emergency Medical and Health Services in Pennsylvania*, in PENNSYLVANIA MEDICINE, June 1971), I commend it to you.

I urge you to develop and sponsor practical methods to insure improved distribution of medical services in this State. We are now working with the Secretary of Health in this direction. Renewed effort in this area is urged upon you. There must be a better way than a government-sponsored draft. However, I recommend consideration of all alternatives, including this government-sponsored draft, by a proper committee of this Society.

May I remind you of a few of the State Society services that may be reviewed in the green pamphlet of the Pennsylvania Medical Society *Services and Functions*: The Pennsylvania Medical Society Professional Liability Insurance program which is available, innovative and workable, and Blue Shield, which is your program; the Society-Endorsed group insurance programs that include disability income protection, major hospital and surgical expense, Blue Cross and Blue Shield major medical (in capital Blue Cross area only), accidental death and dismemberment, business overhead expense, and term life insurance plans. The work done for the membership by the four councils, innumerable committees and commissions cannot be described here. It is prodigious with many man-hours of time and effort donated to your programs.

Although the Society has many agenda, new and innovative ones are necessary to keep in the forefront of the health field. I refer you to the 1971 Official Reports to the House of Delegates. All of this activity costs money and inflation is forever with us. There are indications that a dollar priority crisis is developing in the Society. With present dues our heads are hardly kept above water financially. A dues increase is unpleasant but this must be considered, as the cost worthiness of each program must be given continued consideration. If planning money is to be available, a dues increase may be justified. Holding the line is not enough; it means moving rapidly backwards on the social treadmill. We must plan for the future! **I recommend a total re-evaluation of dollar priorities by our Finance Committee and the Board of Trustees.**

I would be remiss to overlook political activity and the political potential of our Society. Of necessity we are a political animal. Our future and the future of worthy programs may well decided by the Congress to be elec in November, 1972.

There is room, too, for Comm wealth legislative education as e denced by the remarkable variety health bills recently proposed. It m also be noted that although there i thoughtful physician as Secretary Health, much of the health functi are in the highly questionable area the Department of Welfare. Memora dum 16 is an example of the und standing of the Welfare Department. is obvious that our political anim needs sustenance. Strong support f the Pennsylvania Medical Political A tion Committee is urgent. There a still six counties in our State that not include PaMPAC in annu billing, despite overwhelming eviden that this is the best and most co venient method of collection so f devised. **I recommend that the Sta Society strongly urge the six reluctа counties to include PaMPAC in the billing.**

I want to thank our able ar dedicated Officers, Board of Trustee Administrative Staff and Councils f the helpful indoctrination I have bee exposed to during this past year. Ou progressive and positive thinking Soc ety is willing to adjust as need dictat with no apology for the past. We a moving towards the future, and I ar proud to be part of this organizatio It is true that honest mistakes hav been made in the past and in all prob bility will be made in the future, bu the Pennsylvania Medical Society thinking objectively and positively willing to recognize its deficiences an ready to expand its record of service Together we will face squarely ou many problems for the good of society I anticipate a pleasant and productiv year ahead working for and with th Society, and especially shoulder-to shoulder with one of our finest assets the Woman's Auxiliary. The purpos of the Woman's Auxiliary is our pur pose, and every husband knows th significance of his wife's opinion.

All of the aforementioned peopl have faith in the basic integrity of thi Society. I have faith in this Society and I know that you share this faith with me. ☐ *This address was delivered at the opening session of the 1971 PMS House of Delegates.*

Careers in Health Program — Help in a Crisis

MRS. JAMES M. O'LEARY
Sixth District Councilor
Past Chairman, Health Careers Committee
PMS Woman's Auxiliary

The health manpower shortage in the United States has come acute:

- The Health Industry will be the nation's largest industry by 1975.
- Demand for allied health personnel has expanded from one for each physician to twenty for one.
- 250 health related occupations exist today.
- 500 health related occupations may be required in the next five years.

The solution lies in recruitment of our youth through our hools— NOW.

The Woman's Auxiliary in conjunction with the county edical societies and the PMS Council on Public Service s developed a Health Careers Recruitment program esently operating on the high school level. Presentations films and health oriented school assembly programs iden- y interested students who are then given the opportunity form Careers in Health Clubs. Guidance in formulating ub programs and organizing field trips is offered.

In reality, recruitment starts at an earlier age than in the st. With our youngsters' early exposure to communi- tion media from comic books and posters to radio and levision, the interest of pre-school and elementary school udents must be sparked. In the middle grades and junior gh schools this interest should be developed through a eater effort to provide health careers information and ca- er exposure.

In the high schools and vocational schools, the recruit- ent efforts should be expanded to include: improved coun- ling by guidance counselors, science teachers, and career ofessionals; work experience in health facilities such as mmunity clinics, school nursing stations and hospitals; d expanded work-study programs where classroom urses are correlated with a working experience.

Recruiting efforts for both junior and senior high school udents includes support of science fair activities. Follow- p on these students will provide motivation for their en- ance into health fields.

Recruitment at the two-year junior college and voca- onal-technical level are concerned with three types of udents: 1) those still undecided on a career, 2) those ishing to change their major, and 3) students who are in- rested in the general area and who want a specific health rvice career which they have not yet identified. For example— a medical corpsman might decide to be a hospital administrator or a sanitary engineer. His need is for information and guidance toward further training in a specific area.

Colleges and universities provide education for three levels of health manpower personnel in short supply: teaching, supervision, and research. Individual guidance is needed so that the student's talents can be matched with health manpower needs. Increased exposure to specialized fields often discloses available opportunities.

The recruitment of the inactive and retired trained health worker should not be overlooked. A career information center could facilitate the mobility of adults into new careers. It is reported that in nursing, 50 to 80 percent of those who take refresher courses return to work. Correct information which is readily accessible can return many of these health workers to active careers.

New training programs bridge the levels of education as we have known them in the past. All programs can be expanded to include regular student curricula, adult education opportunities, on-the-job training, credit equivalences, and greater clinical exposure. Greater vertical mobility (degree oriented) and greater lateral mobility (emphasis on clinical exposure with a possible certificate or degree in a related field) will result. The provision of more economical health care and the improvement of the financial status and morale of lower-paid employees are among the dividends of such programs.

Development of credit equivalency standards can contribute to shortening the time and lowering the cost of additional health manpower. In the field of medical laboratory specialists alone, the Army discharges 1000 specialists each year. Today 100,000 laboratory workers are employed. By 1975, it is estimated that 175,000 will be needed. To help solve this shortage, HEW has requested the development of an equivalency examination to give credit to returning veterans for their service training, thereby relieving the deficit in the field as well as providing careers for returning servicemen.

To find, motivate, encourage, educate, train, and keep these workers in an effort to decrease the health manpower shortage is a joint goal of the woman's auxiliaries, the PMS Council on Public Service, and the county medical societies.

PENNSYLVANIA MEDICINE cancer forum

Radiation Therapy of Cancer

Tumor Sensitivity and Resistance

Although radiation therapy is carried out almost exclusively by the radiologist, the clinician who is familiar with the strengths and weaknesses of this modality can better advise and guide his patients. Rubin and Poulter of the University of Rochester recently addressed themselves to the problems peculiar to radiation therapy.

The ultimate aim of radiation therapy of cancer is to completely destroy the tumor without damaging the surrounding normal tissue. This is an ideal that is practically never reached in practice and a certain amount of residual damage has come to be expected when tumors are treated for cure. Radiologists speak of the selective effect of irradiation. This depends upon three factors: first is the difference in radiosensitivities of the neoplastic and normal tissues. This is not to be confused with the individual radiosensitivities of the neoplastic and normal tissues, which are of lesser importance. The second factor is the difference in recovery rates of the malignant and normal cells. The third factor is the ability of normal tissues to survive fibrous and scar tissue repair; a process damaging to neoplastic tissue.

The concept and definitions of radiosensitivity and radioresistance have changed in recent years due to refined methods of research. Clone counting in tissue culture and tumor transplantation have added a more precise measurement factor to the clinical observation of the tumor. The present definition of a radiosensitive growth is one in which irradiation causes loss of cells by direct action at the tissue level, with little effect due to interference with the blood supply. From the radiotherapist's standpoint it is a tumor that can be eradicated by doses too small to affect the microcirculation. The radioresistant tumor requires larger doses and the tumor injury is caused more by interference with the blood supply than by any direct ionizing effect on the tumor cells.

The response of a tumor to irradiation is notoriously unpredictable. The entire gamut of high sensitivity to high resistance is seen not only in tumors of different tissue origin but in the same tumors in different hosts. In addition, the same tumor in the same host can vary in its radioresponse with the passage of time and subtle changes in the host environment. Understandably attempts to classify tumors on the basis of radiosensitivity have been greatly hampered by this unpredictability. At present it is felt that the response of the microcirculation is the key factor. In the sensitive tumor, the neoplastic cell population is reduced while the vascular bed is preserved. This leads to the "supervascularized effect." In the radioresistant tumor, vascular injury occurs first and tumor reduction is secondary to this. Other factors entering into the classification of tumor response are the familiar ones of response variations to similar doses of radiation and the variations in dosage needed to destroy various tumors.

With these criteria the greatest sensitivity to irradiation is seen lymphoma, leukemia, seminoma, dy germinoma and granulosa cell ca cinoma. Somewhat less sensitive a squamous cell carcinoma of th oropharynx, esophagus, bladder, ski and cervix.

In the middle range are the vascul and connective tissue elements tumors, astrocytomas, and tumors growing cartilage and bone. Relativel insensitive are carcinomas of th breast, salivary glands, liver, kidney and pancreas. Also in this resistan group are thyroid and colon ca cinomas, liposarcomas, chondrosa comas and osteogenic sarcomas.

Most resistant of all are tumors muscle and nerve tissue: rhab domyosarcoma, leiomyosarcoma an ganglioneurofibrosarcoma.

Another group of factors must be su perimposed on this classification. As corollary to the above, the tissue of ori gin has its own sensitivity level and thi is directly related to the sensitivities o tumors arising from them. At the cellular level, the sensitivity is varied by the degree of differentiation of the cells the rate of mitosis, the location of the cell in the mitotic cycle, and the mitotic potential of the tumor cells. At the subcellular level it is possible, in some instances, to use DNA as an index of radiosensitivity. In addition, as is well established, the vascularity of the surrounding tissues and availability of oxygen are important sensitivity determinants.

(To be continued)

CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.

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Consommé	29	Tomato	69
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Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

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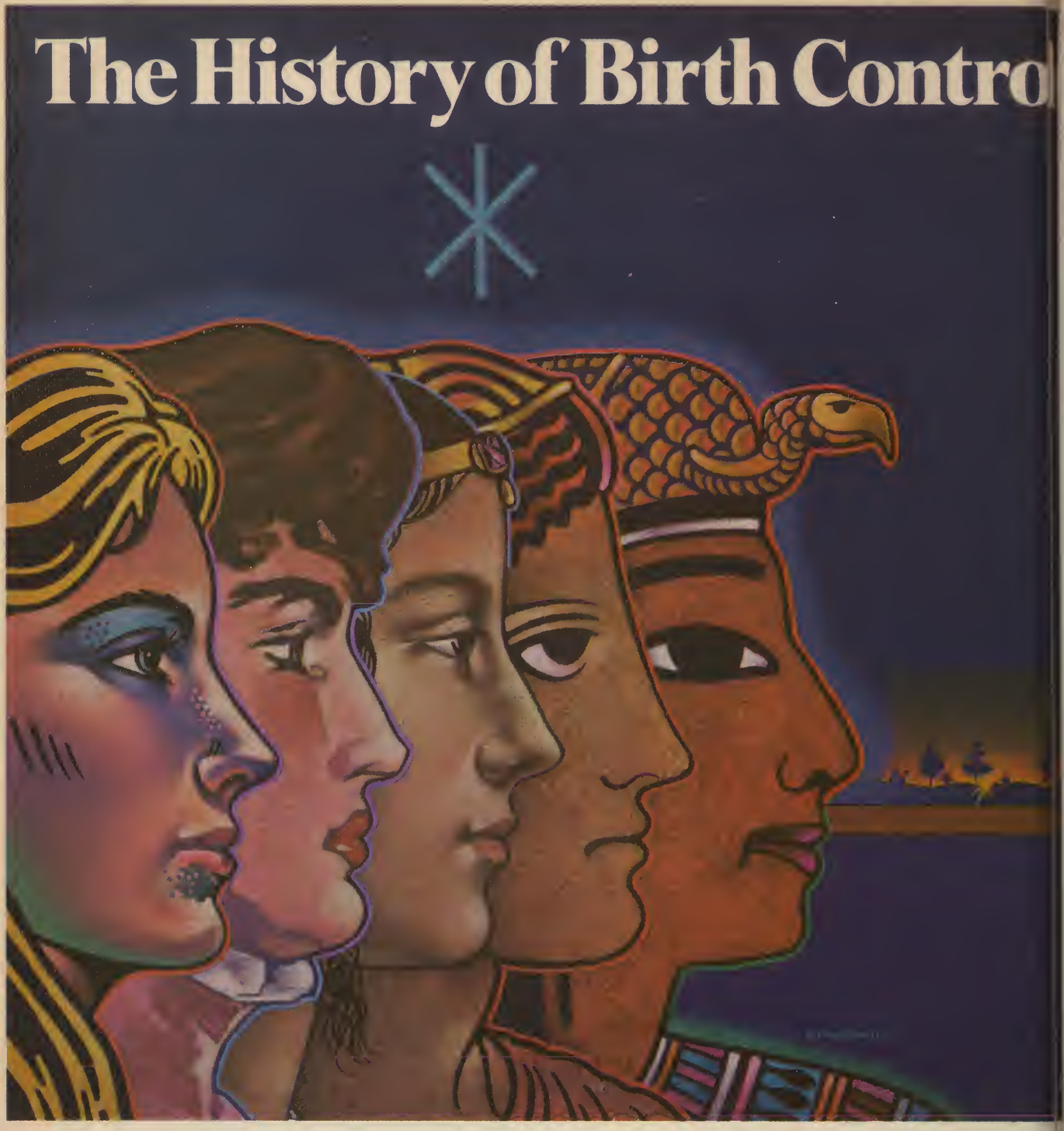
The History of Birth Contro



After a 4,000-year search, have women finally found freedom?

Abortion and infanticide have, throughout history, been the final and desperate resort of women who were unable to control their fertility, but for almost 4,000 years they have sought ways to prevent conception.

In ancient Egypt they used pessaries of crocodile dung or tried to clog the motile sperm with honey and a gumlike substance. The women of Islam used tampons of pomegranate pulp and rock salt. In Japan they burned little balls of "burning grass" on the *mons veneris* or, more practically, tried to cover the mouth of the uterus with disks of oiled bamboo tissue paper. In the 18th Century in France upper-class women rediscovered the vaginal sponge, a device mentioned in sources as old as the Talmud.

It may seem now that such advances as oral contraception and the IUD have freed women from this often fruitless search and consequer suffering, but there are millions of women in t United States and elsewhere who have less knowledge of, and less recourse to, contracep than Egyptian women of the Twelfth Dynasty. Nothing is more urgent to all of us than to brin them help. We cannot long support the ecolog pressures of an additional 70 million Earth inhabitants each year.

Searle contributions to the science of contraception

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Demulen (for its low estrogen and Searle's progestin) and Ovulen (with its wide physician and patient acceptance) offer almost complete contraceptive effectiveness and a low incidence of side effects—both with a choice of pill-taking schedules...simple "Sunday-starting" and patient-proof Compack® tablet dispensers.

Actions—Ovulen and Demulen act to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen and Demulen depress the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note—Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen and Demulen are indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality conducted in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study of Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or completé loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen and Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals Endocrine and possibly liver function tests may be affected by treatment with Ovulen or Demulen. Therefore, if such tests are abnormal in a patient taking Ovulen or Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen or Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen or Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen or Demulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen or Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med J. 2:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem 90:365-380 (Nov.) 1969.

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meetings

NOVEMBER

Annual Scientific Meeting of American Society of Cytology, **November 3-6**, Hilton Hotel, Washington, D.C. For further information contact: Warren R. Lang, M.D., Secretary-Treasurer, 7112 Lincoln Dr., Philadelphia 19119.

American College of Physicians, **November 5-6**, Philadelphia. Contact: Francis J. Sweeney, Jr., M.D., Thomas Jefferson University Hospital, 11th and Walnut Streets, Philadelphia 19107.

American College of Physicians, **November 12-13**, Pittsburgh. Contact: Donald W. Bortz, M.D., 517 First National Bank Building, Greensburg, Pa. 15601.

National Society for the Prevention of Blindness, **November 17-19**, Roosevelt Hotel, New York City.

American Cancer Society, **Nov. 4-6,** New York City. Contact: Lane W. Adams, 219 E. 42nd St., New York City 10017.

American Heart Association, **Nov. 11-14,** Anaheim, Cal. Contact: Dr. James M. Hundley, 44 E. 23rd St., New York City 10010.

American Association of Inhalation Therapy, Philadelphia, **Nov. 14-17.** Contact: Mark T. Bowers 3554 Ninth St., Riverside, Cal. 92501.

Philadelphia Allergy Society, **Nov. 17,** at College of Physicians, Philadelphia. Topic: "Urticaria and Angioneurotic Edema," 8:30 p.m.

Annual Clinical Convention of the American Medical Association, **Nov. 28-Dec. 3,** New Orleans, La.

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Director, Cardiovascular-Pulmonary Division
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Stanton Segal, M.D. ——— "The Ins and Outs of Membrane Transport"
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Dr. Limberger Reviews 'Rewarding' Year in Office

WILLIAM A. LIMBERGER, M.D.
PMS Past President

A year can seem long or short, and since I was installed as President of the Pennsylvania Medical Society, it has been a very short one. It has also been a very busy, enjoyable and rewarding year for me.

The Society has not accomplished all of its objectives, but on the whole it has been a successful year, and I would like to briefly review with you some of our new programs which have been activated.

Group Professional Liability Insurance Program

This program, underwritten by the Argonaut Insurance Company of California and administered by Parker and Company Inc. of Pennsylvania, became operational on June 1, 1971, and over 700 members of the Society have been insured since that date. A Commission on Professional Liability Insurance consisting of one member from each Councilor District has been formed with three ex officio representatives consisting of Pennsylvania Medical Society legal counsel, an Argonaut representative and a Parker and Company representative. Each of the twelve Councilor Districts will form an Insurance Committee composed of at least five members. The State Commission will actively participate in the program, including enrollment activities, review of all appeal cases pertaining to coverage restrictions, rejected applications and cancellations, periodic review of all pertinent statistical data including claim and loss experience, earned premiums, reserve and investment income, determination of premium rates and review of any claim or suit settlement dispute between an insured member and Argonaut.

The initial base rate level for the program is comparable to that followed by the largest writer of physicians' and surgeons' professional liability insurance in Pennsylvania.

During the months that the Sub-Committee on Medical Liability Insurance of the Council of Medical Service has worked on this program, it has been my privilege to attend most of these meetings and to have met several of the principal officers of Argonaut and Parker. I have been very much impressed with these officers. It is for this reason, in addition to the soundness of the company, the care with which the program was planned, and the active part to be played by our Commission on Liability Insurance in its management, that I am firmly convinced of the excellence of the program. This October, with the expiration of my present insurance contract, will find me enrolled in our new group plan.

Excess Major Medical Plan

This $100,000 excess major medical plan with either a $15,000 or $25,000 deductible is designed for members of our Society and underwritten by the Lumbermens Mutual Casualty Company. The 60 month benefit period commences on the date that the deductible is exceeded and pays 80% of the covered expenses incurred during the benefit period to an aggregate max-

imum benefit of $100,000 for any sickness or illness. There are two limitations - one for nervous or mental disease for which the covered expenses are limited to $10,000 and one when confined to a convalescent nursing home in which coverage is 50%.

Two distinct advantages are: (1) once insured, the insurance cannot be cancelled by the company nor its renewal refused as long as the insured pays the required premium, continues his Pennsylvania Medical Society membership and does not enter Military Service. The second advantage is that if the insured member dies, the insurance of the spouse and insured dependent children under 23 years of age remains in force upon proper premium payments.

The premiums are quite reasonable and considerably less than you would pay if enrolled as an individual. It is to your advantage to investigate this program.

Pennsylvania Medical Care Foundation

You all remember that the 1970 House of Delegates approved in principle the concept of a Pennsylvania Medical Care Foundation for further development and presentation to this House of Delegates. The Council on Medical Service assigned this responsibility to a newly organized Sub-Committee on Medical Care Foundation which has devoted many hours of work to this task during the past year. Discussions have been held with organizations such as Blue Cross, Blue Shield, Hospital Association of Pennsylvania, Keystone Medical Society, Pennsylvania Osteopathic Medical Society, Commonwealth Insurance Department and the Health Insurance Council to determine the nature and extent of involvement and cooperation to be expected from these organizations. Discussions and negotiations have been held with the Department of Health, Education and Welfare, the Social Security Bureau of Health Insurance, Pennsylvania Department of Public Welfare, the United States Senate Finance Committee staff and other appropriate organizations regarding developmental grants and possible involvement of each in an operational grant.

Articles of Incorporation and Constitution and By-laws have been developed and were approved by the Board of Trustees at its March 1971 meeting. Due to the possibility of passage of certain impending state legislation, the Board of Trustees directed legal counsel to promptly proceed with incorporation in consultation with the Sub-Committee on Medical Care Foundation.

A detailed report concerning the organization and operation of the Pennsylvania Medical Care Foundation has been submitted to you by the Council on Medical Service in their Supplemental Report B. If you have not done so, be sure to read it completely.

In March 1971 a letter was received from Paul J. Sanazaro, M.D., Director of the National Center for Health Services Research and Development of the Department of Health, Education and Welfare, announcing a proposed research project to be conducted by several State Medical Societies or other interested groups and directed toward improving the access and quality of health and medical care and toward moderating the cost of such services, with particular attention paid to the mechanism of health care review. Interested groups were asked to file a grant application for support for such a program. With the approval of the Board of Trustees, a grant application for an Experimental Medical Care Review Organization was filed by the State Society in May 1971. After considerable correspondence and several visits to Rockville, Maryland, the grant application was approved and the Society was awarded a planning grant in the amount of $57,120 for the period July 1, 1971 to June 30, 1972. With certain indirect costs, this grant totals $76,000. The Board of Trustees, at its August meeting, allocated the sum of $30,000 to the project for the same period of time. Pennsylvania Blue Shield has approved a contribution by way of manpower and computer time which will be worth over $150,000. The Allegheny County Medical Society Foundation has granted the sum of $5,000, and the Western Pennsylvania Regional Medical Program has pledged services valued at $11,440. Additional contributions from industrial organizations in Pennsylvania are being solicited, and it is anticipated that th operating budget for the year will b over $200,000 which will enable th Pennsylvania Medical Society's Medi cal Care Appraisal Project to carry ou its objectives. The project is expecte to extend over three years and the ac tivities planned for the second an third year have been approved b HEW subject to the availability c funds.

This program is one of the most ex tensive and important projects eve carried on by the Pennsylvania Med cal Society. As you know, the primar purpose of the Pennsylvania Medica Care Foundation is to develop a mech anism for providing an alternat means of financing and deliverin health care at a cost reasonable to bot the consumer and the provider. It wi also complement the evaluation an development of continuing program in medical education sponsored by th Pennsylvania Medical Continuing Ed ucation Institute.

This program will be thoroughl discussed at a Special Reference Com mittee tomorrow afternoon, and it i recommended that the House of Del gates whole-heartedly support this pro gram.

Pennsylvania Medical Continuing Educational Institute

At the 1970 meeting of the House o Delegates, the members endorsed i principle the concept of an institute fo continuing education which would b jointly sponsored and financed initiall by the Pennsylvania Medical Societ and other interested organizations The House directed the Council o Education and Science to proceed wit submitting a complete plan to th Board of Trustees and Councilors a soon as possible.

On January 16, 1971 the Board o Trustees and Councilors approved th philosophy, articles of incorporatio and by-laws of the Pennsylvania Medi cal Continuing Educational Institute Following this a letter was sent t twenty-one organizations in the Stat who are interested in continuing edu cation, seeking their approval of th philosophy, the articles of incorpo ration and by-laws. To date approva has been received from the Hospita Association of Pennsylvania, the dean

of the seven medical schools, the Western Pennsylvania Regional Medical Program, the Greater Delaware Valley Regional Medical Program, the Pennsylvania Tuberculosis and Respiratory Disease Association, the Pennsylvania Department of Public Welfare, the Pennsylvania Heart Association and the Pennsylvania Division of the American Cancer Society.

Articles of Incorporation have been signed by representatives of the Pennsylvania Medical Society, the Pennsylvania Osteopathic Medical Association and the Keystone Medical Society and forwarded to the State for incorporation. When this has been approved by the State, the organizational structure, the staff and the funding necessary to operate such a program will be developed. It is hoped to have this organization functioning in the near future and that overlapping and duplication of programs will be avoided, together with making accredited programs available in all areas of the state.

Emergency Medical And Health Services In Pennsylvania

I would like to call your attention to an exceptionally fine white paper on Emergency Medical and Health Services in Pennsylvania compiled by the Pennsylvania Medical Society 1970 Commission on Emergency Medical Services. It was published in the June 1971 issue of Pennsylvania Medicine. Five thousand copies have been distributed to county, municipal and state officials, hospitals and other agencies interested in Emergency Medical Care. Its primary objective is to eliminate the many obstacles to the delivery of good emergency medical care. The publication is a must for physicians engaged in emergency medical care.

The Legislative Field

On January 5, 1971, our Pennsylvania Legislature came to Harrisburg for the first year of a two-year session. The first nine months of this first year were spent struggling with the biggest problem facing Pennsylvania — the matter of adequate taxes for funding ever-increasing spending programs. I will not debate with you today whether some of these programs are necessary. I can only report that many of the health and welfare programs in which Medicine has an interest were not being adequately financed, and hopefully, with the passage of a new tax, some of these programs will be better off. I might add that five of the last seven state budgets were not completed prior to their effective beginning dates, nor were they adequately funded when they were enacted into law. In addition, there was a total failure on the part of the Legislature to resolve revenue needs in 1968, 1969 and 1970; and 1970 was the first time in history to pass on one of these incomplete budgets and mandate the incoming administration to a $1 million-a-day deficit.

Although most of the Legislature's time was spent trying to solve the tax and budget dilemma, over fifty bills of interest to Medicine have been introduced into the Legislature. These cover areas of abortion, blood banks, drugs, medical liability, professional licensure — all the way to our old friend, chiropractic. Many of the bills are caused to be introduced as a result of action taken by this House, and/or the Board of Trustees. Legislative positions of the Society are determined by you and your officers, and are transmitted to the Legislature in form of bills, amendments and testimony.

It is too early to tell how successful we will be during this legislative session, since the game will not be over finally until the end of 1972, but we have reason to be hopeful in some of our attempts. Perhaps some of the most important legislation is in the medical/legal area. We have seen the Senate pass a measure to limit the liability of physicians and county medical societies when they participate in mass immunization programs. The Senate has also passed a measure to prohibit attorneys from contracting with injured patients on a contingency basis, a problem which has vexed this House for several years.

Legislation is also moving in the area of eliminating the implied warranty from the transfusion of blood. These are all very critical and desperately needed pieces of legislation. We have also participated in the design of much legislation, including the "Drug, Device and Cosmetic Act of 1971" and the "Alcohol and Narcotic Abuse Control Act," and have worked a great deal of time this year on the design of a new Medical Practice Act.

We are also on the threshold of seeing permitted the establishment of Medical Examiner systems in those jurisdictions who feel able to have them. These are all legislative "musts" as far as the Society is concerned, and, in most instances, they have been requested by you, the House of Delegates.

This is an extremely important activity of the State Medical Society, and it must continue. However, to make this legislative activity successful requires the active support of all of the county medical societies in contacting their Representatives in Harrisburg on crucial legislation as it is being debated in the House or Senate. You will always have ample notification when help is needed.

However, in order to have the support of our legislators we have to help elect individuals who are sympathetic to the views of medicine, and it is in this field that PaMPAC can play a very important part. This requires money, and the source of it should be from the members of the Pennsylvania Medical Society through contributions to PaMPAC.

It is recommended that the House of Delegates again reaffirm its support of PAMPAC and urge all members of the Pennsylvania Medical Society to become active members of PAMPAC.

Public Relations

We are constantly being reminded that the public image of the physician is a poor one. Personally I get a little irritated with this statement, particularly when I look at the grotesque and distorted image of the average accuser. Nevertheless, we do have to continue to improve our relations with the public. Of all the different means of communication with the public, television is the most successful and likewise the most expensive. This past year an hour documentary on the Health Crisis was produced and shown over seven television stations in the State which gave us good coverage. It was well received and we believe helped us a lot. The coming year should see the

production of other documentaries in other phases of health and should receive our continued support. The current documentary film is available to county medical societies and any public group wishing to show it.

Membership

The total number of members in the Pennsylvania Medical Society has not changed greatly in the past eight years ending in December 1970, ranging from a low of 12,186 in 1970 to a high of 12,318 in 1968. However, in football parlance, there does seem to be a shift to the right, that is - an increase in the average age of our membership. There has been a decrease, in the regular, resident and military membership and an increase in the associate, affiliate and disability classifications. Furthermore, the figures suggest that we may not be attracting as many new young physicians as we should.

Last fall a letter was written to all physicians licensed in Pennsylvania who were not members of the Pennsylvania Medical Society. This included all residents and also all interns who, while not licensed, were eligible for membership in the Pennsylvania Medical Society. A total of 3,000 letters were mailed, and 1,200 answers were received. This list of physicians naturally included physicians who had retired, some who were living in other states or countries and physicians engaged in other phases of medicine not associated with the active practice of medicine. We have heard from physicians in all of these different categories, and the answers have been most interesting. The questions asked were: (1) have you ever been a member of a county or state medical society? (2) if no - why not; (3) would you be interested in joining or attending a meeting to discuss membership in a county medical society? We heard from a physician in India who is finishing 50 years of practice in ophthalmology in that country; from physicians who live in an adjoining state, and from many other groups. Some physicians who live in an adjoining state, belong to a medical society in that state but practice in Pennsylvania. Some full time physicians thought the expense of membership in the county and State medical society was too much in addition to dues in their specialty and research societies. Others believed that the county and State medical societies spoke only for the physician in private practice and had little to offer physicians engaged in other phases of medicine. It was surprising the number who stated they had never been asked to join. Virtually all of these letters have been answered.

In addition each county medical society has been encouraged to change their by-laws to permit interns to join. A list of all interns and residents working in each county has been sent to the secretaries of each county medical society and the societies were urged to enroll them as members.

At the end of 1970 our active membership in the AMA had decreased below 11,000 so that we lost one delegate to the American Medical Association House of Delegates. As of September 1, 1971, we had 10,325 active AMA members which looks as if we will have enough members by December 30 to qualify us for a 12th delegate.

It is recommended that each county medical society contact all physicians in their county who are not members of their society and enroll them as members.

Facts And Figures

One of the questions most frequently asked me in the past year has concerned the amount of time spent in carrying out the duties of this office and how I could continue to carry on the practice of medicine at the same time. Last fall I decided I would keep a log and summarize my activities to this House. The following statements include all visits on behalf of the State Medical Society and certain American Medical Association activities.

The total mileage traveled by car was 21,380 and by air 7,880, making a grand total of 29,260. Forty-four county medical societies were visited, mostly individual visits, a few combinations of more than one county.

The annual meetings of the State Medical Societies of Delaware, Maryland, New Jersey, New York, Ohio and West Virginia were attended. These were delightful occasions, and my wife and I were extended the utmost kindness and hospitality. I am delighted that we have most of the presidents of these Societies with us tonight.

The annual meetings of the following State Professional Organizations were also attended: The Pennsylvania Bar Association, the Pennsylvania Osteopathic Medical Association, the Pennsylvania Pharmaceutical Association, the Pennsyvania Dental Society, the Pennsylvania Association of Medical Assistants, the Pennsylvania Cancer Society, the Pennsylvania Health Council, the Pennsylvania Academy of General Practice and the Pennsylvania Nurses Association.

American Medical Association meetings included the Scientific Meeting in November 1970, and the Annual Meeting last June, and two meetings of the Health Care Financing Committee of the Council on Medical Service.

In most of the visitations to the County Medical Societies I was accompanied by a member of the Administrative Staff who participated in the program which we gave. I am deeply grateful to these men for their help and assistance, and I want to thank their wives for allowing them to accompany me on these trips which frequently involved overnight stays.

The experience of visiting the County Medical Societies was well worthwhile, and we were particularly gratified by the interest shown and the questions asked about our various programs and problems. We hope we were able to better acquaint the membership with the various State Society activities and to show them where their dues dollars go. We greatly appreciate the kindness and hospitality shown by all the county medical societies at our visitations. One thing is sure - if you want to become better acquainted with your state and meet a fine group of professional men - take this job.

Finally, I want to thank all the administrative staff of the Society and the members of the councils, commissions and committees for their fine support and guidance during the past year. To the members of the House of Delegates my sincere thanks for having given me the opportunity and honor to serve as your President. And last I want to thank my wife for accompanying me on many of my trips, listening to many of my speeches and putting up with my eccentricities.

God bless you all. □

House Approves Foundation Progress

The PMS House of Delegates in session last month directed that work proceed "without delay" on the further development of the Pennsylvania Medical Care Foundation and with the Medical Care Appraisal Project currently underway. The action was taken after a special reference committee of the House spent a full afternoon devoted to testimony concerning the foundation.

The approved reference committee report said, "The concept of the Pennsylvania Medical Care Foundation is indeed sound, and such a foundation will have a salutary effect upon the development of a high quality pluralistic system of medical care delivery."

The House action following a unique reference committee hearing devoted to a single subject was recommended by the Council on Medical Service, the Board of Trustees and in the addresses of President Limberger, and President-Elect Rosemond. The special reference committee, which in effect was the House functioning as a reference committee of the whole, was chaired by Ulysses E. Watson, M.D., of Philadelphia, who was applauded for the manner in which the meeting was conducted. Copies of the report describing foundation progress and the Medical Care Appraisal Project are available on request.

The House-approved reference committee report reads in part as follows:

The Reference Committee was impressed with the interest nd constructive concern expressed by a large contingent of ne House of Delegates. The Reference Committee was leased to note the wide acceptance of the general objectives utlined in the Council's Supplemental Report B (Pennsylania Medical Care Foundation).

The Reference Committee believes that the objectives and ctivities set forth in the Supplemental Report are consistent ith the action of the 1970 House of Delegates directing the ouncil on Medical Service to consider the development of a ealth care financing and delivery mechanism which will erve as a viable alternative to present and proposed methods. Ve wish to commend the Council, its Subcommittee, and taff for an outstanding performance in developing the eport.

Your Reference Committee noted that there was general pproval of the concept of peer review and support of the Research Plan of the PMS - Medical Care Appraisal Project. The Council is to be commended not only for developing the lan but also for obtaining, from other sources, the funds for ts support. In developing the objectives of the Research Plan, the Reference Committee urges physicians in all pecialties, including family physicians, to participate in the levelopment of criteria for medical care appraisal.

Much of the discussion before the Reference Committee eflected interest, concern, confusion, misunderstanding, and nthusiastic support of the concept of the Pennsylvania Medcal Care Foundation. The overall tenor of the testimony was in support of the objectives of the Medical Care Foundation.

Based on this testimony, your Reference Committee recognizes the need for the development of further details of the operational aspect of the Foundation. In particular, the Reference Committee reviewed the draft of the Bylaws of the Pennsylvania Medical Care Foundation. The Reference Committee feels that the Council should further refine the draft of the Bylaws in consultation with county medical societies, hospital medical staffs, and other participating and cooperating agencies.

In pursuing the development of the operational structure and organizational relationships of the Medical Care Foundation, the Council on Medical Service should be urged to continue the development and expansion of cooperative relationships with hospitals, governmental agencies, third parties, and public representatives.

The Reference Committee was impressed with the significance of the proposed Program and its long-range implications, and urges the Council to proceed, without delay, with the activities of the Medical Care Appraisal Project and the further development of the Pennsylvania Medical Care Foundation.

In conclusion, your Reference Committee believes that the concept of the Pennsylvania Medical Care Foundation is indeed sound and that such a Foundation will have a salutary effect upon the development of a high quality pluralistic system of medical care delivery.

Mr. Speaker, **in accordance with this belief, your Reference Committee recommends adoption of this report and Supplemental Report B of the Council on Medical Service.**

Turn page for summary of Foundation Report

Pennsylvania Medical Care Foundation

Summary

During 1969 the Pennsylvania Medical Society's Council on Medical Service recognized the probable development of some type of legislation to control health care costs, particularly hospitalization premiums. The Council also was aware of pending federal subsidies to promote the development of prepaid (capitation) group practice on a more extensive basis as an alternative to present mechanisms of financing and delivering health care. The Council concluded that, while the Pennsylvania Medical Society had been reasonably effective in developing programs to assure proper use of health care dollars, it was apparent that the developing problems of financing health care would require an innovative statewide effort to meet the challenge. The Council agreed that, in view of the increased state and federal legislative efforts, there is a pressing need to develop a more effective mechanism by which practitioners can collectively influence the planning of health care financing and delivery systems.

The Council felt a statewide Medical Care Foundation would be the best mechanism to achieve this objective. The 1970 PMS House of Delegates concurred with the Council's conclusions and approved, in principle, the concept of the Pennsylvania Medical Care Foundation.

One of the primary functions of the Pennsylvania Medical Care Foundation will be to develop statewide systems, with regional variations, necessary to carry out medical audit, utilization review, and claims processing procedures. The Research and Development phase for organizing the Pennsylvania Medical Care Foundation will be carried out by the PMS - Medical Care Appraisal Project which was approved in July of 1971 by the U.S. Department of HEW's National Center for Health Services Research and Development. The primary purpose of the Medical Care Appraisal Project is to develop the procedures necessary for providing an alternative means of financing and delivering quality health care at a cost reasonable to both the consumer and the provider.

In order to achieve this basic objective, the Project will develop comprehensive prospective and retrospective computer claim processing and utilization review systems utilizing the resources of the Pennsylvania Medical Society, Blue Shield, Blue Cross, and the Hospital Utilization Project (HUP). Following the developmental phase, the operational phase will be implemented by adapting the systems to the health service plans offered to consumers by the Pennsylvania Medical Care Foundation on a dual choice basis as an alternative to present delivery and financing methods.

The systems will be designed to: (1) develop the Pennsylvania Medical Care Foundation as an alternative health care financing mechanism for the option of the public; (2) qualify the Pennsylvania Medical Care Foundation as an agency to take leadership in developing a Professional Standards Review Organization (PSRO) and a Health Maintenance Organization (HMO); (3) provide the Pennsylvania Medical Society with adequate resources to assist the Blues and the private health insurance industry in developing more appropriate cost control mechanisms; (4) encourage hospital medical staffs to develop more effective medical audit programs for the benefit of all patients, including those who do not enroll in the Foundation Program. The Program is intended to complement and assist in the development of the post-graduate medical education programs sponsored and/or coordinated by the Pennsylvania Medical Continuing Education Institute by identifying situations where the application of medical knowledge might be improved.

The prospective or prepayment claim processing systems and retrospective utilization review systems developed by the PMS Medical Care Appraisal Project (MCAP) will be adapted to the Foundation health care plans and utilized as both quality and cost control mechanisms. In order to achieve the objectives of the Medical Care Foundation, it will be necessary to modify and extend present claim processing, utilization review, and medical audit procedures for both inpatient and ambulatory services. The claim processing system will be designed to identify individual claims which deviate from established PMS criteria. The utilization review system will be designed to identify deviations in patterns of care, utilization by institutions or individual physicians, and potential deficiencies in medical education.

The systems are intended to provide effective quality and cost controls, reducing both the bureaucratic interference with medical practice and the administrative red tape for reimbursement to physicians and hospitals and to provide a basis for more effective post-graduate medical education programs. Physicians who agree to participate in the Foundation Program will have freedom of choice of type of practice (solo, group, closed panel group) and method of reimbursement (fee-for-service, salary, or capitation).

The activities of the Pennsylvania Medical Care Foundation will be governed by a Board of Directors which will be elected by the Pennsylvania Medical Society's House of Delegates. It will be made up of practicing physicians, representatives of cooperating organizations, and public representatives. The Research Plan of the Medical Care Appraisal Project was submitted to the 1971 PMS House of Delegates and approved. The details of the operational format of the Pennsylvania Medical Care Foundation will be developed for presentation at the 1972 meeting of the House of Delegates.

INTERMITTENT COURSES

Listed below are courses of continuing medical education which include a series of two or more sessions on various subjects. To determine the specific topic on any given day, contact the director at the address given in the course listing.

CODE KEY

S—Designed for full-time specialists
AAGP—American Academy of General Practice
ACGP—American College of General Practitioners in Osteopathic Medicine and Surgery
AMA—AMA Accredited Educational Institution (Eligible for AMA Physician's Recognition Award Credit)
PMS—Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
M.S. Hershey—Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Pitt—University of Pittsburgh School of Medicine
Penn State—Pennsylvania State University
Temple—Temple University School of Medicine
U. of Pa.—University of Pennsylvania School of Medicine
MCP—The Medical College of Pennsylvania

CARDIOVASCULAR DISEASES

Sayre; June 28, 1971—February 1, 1972

Rotating Specialty Seminar/Cardiovascular Disease; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 17 weeks; 17 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Sewickley Valley Hospital November 3-24, 1971

Hypertension and Its Complications; in cooperation with Pitt; Wed. ea. week. Contact Mrs. Patti Myers, Medical Staff Secretary, Sewickley Valley Hosp., Blackburn Rd., Sewickley 15143.

DERMATOLOGY

Sayre; August 10, 1971—June 6, 1972

Rotating Specialty Seminar/Dermatology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 6 weeks; 6 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

ENDOCRINOLOGY

Sayre; July 20, 1971—May 23, 1972

Rotating Specialty Seminar/Endocrinology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 9 weeks; 9 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

FAMILY MEDICINE

Hershey; September 28, 1971—June 27, 1972

Newer Aspects of Family Medicine; at Hershey; 1 hr. per day; 1 day per week; 40 weeks; 40 hrs. AAGP credit approved. Contact Thomas L. Leaman, M.D., Chrm., Dept. of Family & Community Medicine, M.S. Hershey, Hershey 17033.

GASTROENTEROLOGY

Philadelphia; March 3 - April 7, 1972

AMA — Gastroenterology Seminar (Basic Concepts in the Modern Diagnosis & Management); at Hahnemann; 3½ hrs. per day; 1 day per week; 6 weeks; 21 hrs. AAGP credit requested; fee = $60. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

GENERAL MEDICINE

Abington Memorial Hospital; September 15—December 1, 1971

Psychiatry for the Family Practitioner; by Montgomery County Academy of Family Practice; 2½ hrs. per day; 1 day per week; 10 weeks; 25 hrs. AAGP credit requested; max. enrollment=30; fee=$25. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Abington Memorial Hospital; January 20—March 21, 1972

Endocrine Problems in Family Practice; by Montgomery County Academy of Family Practice; 2½ hrs. ea. day; 1 day ea. week; 10 weeks; 25 hrs. AAGP credit requested; max. enrollment=30; fee=$25. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Allentown Hospital; September 9, 1971 - June 8, 1972

AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; 1 day ea. mo.; 3 hrs. ea. day; 30 hrs. AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Altoona Hospital; October 7, 1971 - May 18, 1972

AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; 2 days ea. mo.; 2 hrs. per day; AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 16, 1971 - May 18, 1972

AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; at St. Luke's Hosp.; 1 day ea. mo.; 3 hrs. per day; AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford; October 19, 1971 - May 16, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; at Penn Hills Club; third Tues. ea. mo. except Dec. and Jan.; 18 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Chester; September 7, 1971—May 23, 1972

AMA— Continuing Education Program; at Crozer-Chester Med. Center; by Hahnemann; 2 hrs. per day; 1 day per week; 38 weeks; 76 hrs. AAGP credit requested; 76 hrs. ACGP credit approved. Contact Frederick K. Heath, M.D., D.M.E., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Coatesville VA Hospital; September 23, 1971—May 25, 1972

The Laboratory and the Clinician; 1 hr. a day; 1 day per mo.; 9 hrs. AAGP credit requested. Contact John C. Cottrell, M.D., Chief, Laboratory Services, Coatesville VA Hosp., Coatesville 19320.

DuBois Hospital; February 10 - April 13, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; Thurs. ea. week; 30 hrs. AAGP credit requested, fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

East Stroudsburg; October, 1971 - April, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and M.C. of Pa.; at General Hosp. of Monroe County; 3 hrs. per day; 1 day per mo.; 6 mos.; 18 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Easton Hospital, September 15, 1971 - June 21, 1972

AMA— What's New in Basic Concepts of Each Sub-Division of Medicine; by Hahnemann; 1½ hrs. per day; third Wed. ea. mo.; 12 hrs. AAGP credit approved. Contact Horace Y. Seidel, M.D. Dir., Dept. of Medicine, Easton Hosp., 21st & Lehigh Sts., Easton 18042.

Erie; September 16, 1971-May 12, 1972

AMA — A Program of Continuing Medical Education; at St. Vincent Hospital; by Jefferson and Penn State; 3 hrs. per day; 1 day per week; 12 weeks; 36 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Gettysburg; January 11 - April 19, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; at Annie Warner Hospital; every-other week, alternating Tues. and Wed.; 24 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Hanover General Hospital; October 20, 1971 - May 18, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; one ea. mo. except Jan. and Feb.; 12 hrs. AAGP credit requested. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Harrisburg; September 30, 1971—January 20, 1972

Continuing Education Program 1971-1972; at Community General Osteopathic Hosp.; 8 Thurs.; 2½ hrs. per day; fee=$60 ($10 ea. single session); AAGP and ACGP credit requested. Contact Charles M. Worrell, D.O., D.M.E., Community Gen. Osteopathic Hosp., 4300 Londonderry Rd., Harrisburg 17109.

Hazleton State General Hospital; September 1 - June 1

AMA (required credit) — A Program of Continuing Medical Education; by U. of Pa.; 1½ hrs. ea. day; Thurs. ea. week; 36 weeks; 54 hrs. total; 40 hrs. AAGP credit approved. Contact Robert Gunderson, M.D., D.M.E., Hazleton State Gen. Hosp., Hazleton 18201.

Johnstown; September 23, 1971-March 9, 1972

AMA — A Program of Continuing Medical Education; at Conemaugh Valley Memorial Hosp.; by Jefferson and Penn State; 7 sessions; 2 hrs. AAGP credit approved for ea. session. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Kittanning; December 2 - 16, 1971

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; at Armstrong County Memorial Hosp.; every Thurs.; 6 hrs. AAGP credit requested, fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Lancaster General Hospital; September 2-December 16, 1971

Ambulatory Health Care Conferences; 1½ hrs. ea. Thurs. (except Thanksgiving); 15 hrs. AAGP credit approved; no fee. Contact John H. Esbenshade, Jr., M.D., D.M.E., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17604.

Lancaster General Hosp.; September 7, 1971 May 30, 1972

Continuing Education Program; 1 day per week; 3 hrs. per day; 29 days; AAGP credit requested; fee = none. Contact John H. Esbenshade, Jr., M.D., Dir. Med. Educ., Lancaster General Hosp., 555 N. Duke St., Lancaster 17604.

Lancaster Osteopathic Hospital; September 23, 1971 - May 25, 1972

AMA — Continuing Education Program; by Hahnemann; 2 hrs. per day; 1 day per week; 17 weeks; 34 hrs. AAGP and ACGP credit requested. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Lebanon; November 3, 1971 - May 2, 1972

AMA — A Continuing Medical Education Program; by Jefferson and Penn State; at Quentin Riding Academy; 1 day every-other mo.; 2 hrs. per day; 8 hrs. AAGP credit requested; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lewistown Hospital; February 9 - April 12, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; every Wed.; 30 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Lock Haven Hospital; October 20, 1971 - April 19, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; first and third Wed. except holidays; 30 hrs. AAGP credit requested, fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Meadville; September 1, 1971 - May 3, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS; at Meadville City Hosp.; first Wed. ea. mo.; 18 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Philadelphia; September 15, 1971 - May 17, 1972

Continuing Medical Education Seminars; at Methodist Hospital; 1 day ea. mo.; 2 hrs. per day; 18 hrs. AAGP credit requested; fee = none. Contact John N. Giacobbo, M.D., D.M.E., Methodist Hosp., 2301 S. Broad St., Philadelphia 19143.

Philadelphia; October 13 - December 1, 1971

Recent Advances in Medicine; at Temple; 1 day ea. week; 4½ hrs. ea. day; AAGP credit requested; fee=$75. Contact Albert J. Finestone, M.D., Dept. of Med., Temple, Broad & Ontario Sts., Philadelphia 19140.

Philadelphia; January 4 - May 16, 1972

AMA— Current Topics of Interest to the Family Physician; at Jefferson; 2 hrs. per day; 1 day per week; 20 weeks; 40 hrs. AAGP credit requested; fee=$150. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Pittsburgh; August 5, 1971 - June 22, 1972

Post Graduate Medical Education Lectures; at St. Margaret Memorial Hosp.; first, second and third Thurs. ea. mo. except July; 1 hr. per day; AAGP credit requested; min. enrollment=30; fee=none. Contact Paul W. Dishart, M.D., D.M.E., St. Margaret Memorial Hosp., 265 - 46th St., Pittsburgh 15201.

Pittsburgh; September 2, 1971 - June 15, 1972

Psychiatry Seminars in Family Practice; at St. Margaret Memorial Hosp.; 1 day ea. week; 2 hrs. ea. day; 32 weeks; min. enrollment 6; AAGP credit requested; fee=$50 for ea. 10-week series. Contact Paul W. Dishart, M.D., D.M.E., St. Margaret Memorial Hosp., 265 46th St., Pittsburgh 15201.

Pittsburgh; October 17, 1971-March 19, 1972

AMA — Workshops in Medicine; at Western Pennsylvania Hospital; 6 AAGP credit hrs. for ea. course — 6 in series; fee = $20 ea. course (no fee for residents, interns and medical students), luncheon included. Contact Postgraduate Education Secretary, House Staff Office, Western Pennsylvania Hosp., 4800 Friendship Ave., Pittsburgh 15224.

Pittsburgh; October 21, 1971 - June 1, 1972

Seminars for the Primary Physician; at Pitt; 2 hrs. ea. evening; 1 day per week; 27 weeks; 54 hrs. AAGP credit requested; fee=$10 per session ($150 for all 27). Contact William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt, 1022-H Scaife Hall, Pittsburgh 15213.

Pittsburgh; July 14, 1971 - June 23, 1972

Post Graduate Medical Education Lectures —Family Practice; at St. Margaret Memorial Hosp.; every Wed.; 1 hr. ea. day; AAGP credit requested; min. enrollment=20; fee=none. Contact Paul W. Dishart, M.D., D.M.E., St. Margaret Memorial Hosp., 265 - 46th St., Pittsburgh 15201.

Pottsville Hospital; September 2, 1971 - June 1, 1972

AMA —A Program of Continuing Medical Education; by Jefferson and Penn State; first Thurs. ea. mo.; 2 hrs. ea. day; 20 hrs. AAGP credit approved; fee=none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Reading; September 28, 1971—May 23, 1972

1971-1972 Continuing Education Program; at St. Joseph's Hosp.; 4th Tues. of ea. mo. except Dec.; 1 hr. ea. day; 8 hrs. AAGP credit approved. Contact Kenneth M. Schreck, M.D., Med. Dir., St. Joseph's Hosp., Reading 19610.

St. Marys; September 26, 1971 - March 26, 1972

Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust); by PMS, Pitt and Western Pa. RMP; at Andrew Kaul Memorial Hosp.; forth Sun. ea. mo. except December; 21 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Scranton; Fourth Wednesday of each month (except November, December & June)

A Program of Continuing Medical Education; at Casey Inn; by Lackawanna Co. Med. Society and Greater Delaware Valley RMP; 3 hrs. ea. evening; AAGP credit requested. Contact R.N. Shoemaker, Ph.D., Coordinator of Med. Educ., VA Hosp., 1111 E. End Blvd., Wilkes-Barre 18703.

Sellersville; September 22, 1971 - June 15, 1972

AMA —Continuing Education Program; at Grand View Hosp.; by Hahnemann; 2 hrs. per day; 1 day per mo.; 9 months; 18 hrs. AAGP and ACGP credit requested. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Sharon General Hospital; October 20, 1971 March 1, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; first and third Wed. ea. mo.; 30 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Somerset Community Hospital; Fourth Tuesday of each month

A Program of Continuing Medical Education; by Western Pa. RMP and the Regional PG Medical Faculty Project of Lee Hospital, Johnstown; 2 hrs. ea. day; 24 hrs. AAGP credit requested ea. year. Contact William W. Ayres, M.D., Pathologist, Somerset Community Hosp. 225 S. Center Ave., Somerset 15501.

Tunkhannock; March 8 - May 10, 1972

Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust); by PMS and Greater Delaware Valley RMP; at Tyler Memorial Hosp.; second Wed. ea. mo.; 9 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Uniontown Hospital; September 22, 1971 - February 23, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; every-other Wed. except Dec. and Jan.; 24 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Wellsboro; September 15, 1971 - March 15, 1972

Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust) by PMS and Susquehanna Valley RMP; at Soldiers and Sailors Memorial Hosp.; third Wed. every-other mo.; 1 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Williamsport Hospital; September 10, 1971 March 10, 1972

AMA — A program of Continuing Medical Education; by Jefferson and Penn State; second Fri. ea. mo. except Jan.; 3 hrs. ea. day; 18 hrs. AAGP credit requested; fee=none. Contact John H. Killough, Ph. D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

York Hospital; September 16, 1971-April 27, 1972

AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; Thursday each week; 3 hrs. per day; AAGP credit approved 30 weeks; fee = $40 ($8 ea. session). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

HEMATOLOGY

Sayre; July 12, 1972—June 5, 1972

Rotating Specialty Seminar/Hematology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 15 weeks; 15 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

INTERNAL MEDICINE

Abington Memorial Hospital; September 2—December 16, 1971

S-Recent Advances in Internal Medicine; 2 hrs. per day; 1 day per week; 15 weeks; max. enrollment=40 (internal medicine); fee=$30. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Philadelphia; October 6, 1971 - May 31, 1972

AMA — Internal Medicine Reviews; at Hahnemann; 3 hrs. ea. day; 1 day ea. week; 32 weeks; 96 hrs. AAGP credit approved; $175 fee ($50 ea. sub-specialty — Hematology & Medical Oncology, October 6 to November 17; Gastroenterology, November 24, 1971 to February 9, 1972, Dermatology & General Topics, February 16 to April 19; Cardiology, April 26 to May 31). Contact Mrs. Sage Cordell, Asst. Dir. PG Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Pittsburgh; September 13 - October 15, 1971

AMA — Internal Medicine Review Course; by Pitt and Amer. Coll. of Physicians; at Pitt; 3 hrs. a day; 2 day ea. week; 5 weeks; 33 hrs. AAGP credit requested; $50 fee. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt. Scaife Hall, Pittsburgh 15213.

MALIGNANT DISEASE

Reading; Fourth Tuesday ea. month

Tumor Conference; at Community General Hospital. Contact Harold I. Farber, M.D., Dir. Tumor Clinic, Community Gen. Hosp., 145 N. Sixth St., Reading 19601.

NEPHROLOGY

Sayre; September 13, 1971—May 29, 1972

Rotating Specialty Seminar/Nephrology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 9 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

NEUROLOGY

Sayre; August 9, 1971—March 21, 1972

Rotating Specialty Seminar/Neurology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 9 weeks; 9 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Norristown State Hospital; September 13, 1971 - May 8, 1972

Intensive Review of Neurology; 1¼ hrs. per day; 1 day per week; 30 weeks; min. enrollment 8;

ee=$100. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

OBSTETRICS & GYNECOLOGY

Pittsburgh; (dates by arrangement)
Workshops in Family Planning; by Pitt; at Magee-Womens Hosp.; 3½ hrs. per day; 1 day per week; two successive Fridays; 7 hrs. AAGP credit requested; fee=$50. Contact Marvin C. Rulin, M.D., Magee-Womens Hosp., 3400 Forbes St., Pittsburgh 15213.

OPHTHALMOLOGY

Abington Memorial Hospital; September 22, 1971—May 22, 1972
S-Recent Trends on Ophthalmology; 1½ hrs. per day; 1 day per mo.; 9 mos. 13 hrs. total; max. enrollment=15; fee=none. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

PHARMACOLOGY

Philadelphia; September 27, 1971 - January 24, 1972
AMA — Experimental Design, Statistics and Fortran; at Hahnemann; 2 hrs. per day; 2 days per week; 15 weeks; 58 hrs. AAGP credit requested; fee=$300. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia General Hospital; September 29, 1971 - May 31, 1972
AMA — Current Concepts in Clinical Pharmacology; by Hahnemann and American Society for Clinical Pharmacology and Therapeutics; 3 hrs. per day; 1 day per week; 35 weeks; 105 hrs. AAGP credit requested; fee=none. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

PSYCHIATRY

Abington Memorial Hospital; September 27, 1971—June 12, 1972
S-Seminar in Psychiatry; 1½ hrs. per day; 2nd and 4th Mon. ea. mo., 10 mos.; max. enrollment=30; fee=none. Contact William H. Mahood, M.D., Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Abington Memorial Hospital; March 7—May 9, 1972
S-Marital Therapy; 2 hrs. per day; 1 day per week; 10 weeks; max. enrollment=20; fee=$50. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Allentown Osteopathic Hospital; September 22 - December 8, 1971
AMA — Adolescence and the Youth Culture; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks; 20 hrs. AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Carlisle Hospital; September 24 - October 22, 1971
AMA— New Dimensions in Patient Care; by The Institute of Pa. Hosp. and PMS; 2 hrs. per day; 1 day per week; 5 weeks; 10 hrs. AAGP credit requested; fee=$25. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Danville; September 8, 1971 - April 12, 1972
AMA— Psychiatry and Community Mental Health; at Geisinger Med. Center; by The Institute of Pa. Hosp., PMS and PAGP; 2 hrs. per day; 1 day per week; 5 weeks; 12 hrs. AAGP credit requested; fee=$5. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Easton Hospital; September 27, 1971 - June 26, 1972
AMA — Psychiatry in Medical Practice; by Hahnemann; 1½ hrs. per day; 1 day per mo.; 9 mos.; 13½ hrs. AAGP credit requested; fee=none. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Lancaster General Hospital; October 20 - November 17, 1971
AMA— Drug Abuse and Alcoholism; by The Institute of Pa. Hosp., PMS and PAGP; 2 hrs. per day; 1 day per week; 5 weeks; 10 hrs. AAGP credit requested; no fee. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Lancaster General Hospital; November 24-December 15, 1971
AMA — Sexual Problems in Family Medicine; by Hahnemann; 1½ hrs. ea. Wed.; AAGP credit approved; no fee. Contact John H. Esbenshade, Jr., M.D., D.M.E., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17604.

Norristown State Hospital; September 10, 1971 - May 12, 1972
S — Intensive Review of Psychiatry; 1¼ hrs. per day; 1 day per week; 31 weeks; min. enrollment=8; fee=$100. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown State Hospital; October 1 - December 10, 1971
S — Group Therapy; 1½ hrs. per day; 1 day per week; 10 weeks; min. enrollment=8; fee=$50. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown State Hospital; January 7 - February 18, 1972
S — Management of Adolescent Behavorial Disorders; 1½ hrs. per day; 1 day per week; 7 weeks; min. enrollment=8. fee=$30. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown State Hospital; March 3 - May 19, 1972
S — Family Therapy II; 1½ hrs. per day; 1 day per week; 10 weeks; min. enrollment=8; fee=$50. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown; (dates to be announced)
AMA— Drug Abuse and Alcoholism; at Montgomery Co. Mental Health Clinics; by The Institute of Pa. Hosp., PMS and PAGP; 2 hrs. per day; 1 day per week; 12 weeks; 24 hrs. AAGP credit requested; fee=$25. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; September 7, 1971 - June 6, 1972
S/AMA — Advances in Psychiatry and Behavorial Sciences; by Institute of Pa. Hosp. and U. of Pa.; at the Institute; 1½ hrs. ea. day; 1 day ea. mo.; 10 mos.; fee=$50. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; September 15 - November 17, 1971
AMA — Sexual Problems in Medical Practice; by Hahnemann; 2 hrs. ea. day; 1 day ea. week; 10 weeks; AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 4 - December 6, 1971
S/AMA — Family Therapy; by the Institute of Pa. Hosp. and U. of Pa.; at Philadelphia Child Guidance Clinic; 2½ hrs. per day; 1 day per week; 10 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 6 - December 8, 1971
S/AMA — Marital Therapy; by the Institute of Pa. Hosp. and U. of Pa.; at Marriage Council of Philadelphia; 2½ hrs. ea. day; 1 day per week; 10 weeks; fee =$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 6, 1971 - February 16, 1972
AMA — Psychiatric Problems of Children; by Hahnemann; 2 hrs. per day; 1 day per week; 18 weeks; 36 hrs. AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Edu. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 7, 1971 - February 17, 1972
AMA— Medical Hypnosis; at The Institute of Pa. Hosp.; by The Institute, PMS and PAGP; 4 hrs. per day; 1 day per week; 20 weeks; 80 hrs. AAGP credit requested; fee=$150. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 13, 1971 - May 17, 1972
AMA — Seminars in Psychotherapy: Short-term, Crisis & Supportive Therapies; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks per seminar; AAGP credit requested; fee=$150 for 30 weeks, $75 for 10 weeks. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; December 2, 1971 - April 20, 1972
AMA— New Dimensions in Patient Care; by The Institute of Pa. Hosp., PMS and PAGP; at The Institute; 2 hrs. per day; 1 day per week; 18 weeks; 36 hrs. AAGP credit requested; fee=$100. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 10 - March 13, 1972
S/AMA — Behavior Therapy; by the Institute of Pa. Hosp. and U. of Pa.; at Hospital of U. of Pa.; 2 hrs. per day; 1 day per week; 10 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 10 - February 14, 1972
S/AMA — Psychopharmacology; by the Institute of Pa. Hosp. and U. of Pa.; 1½ hrs. per day; 1 day per week; 6 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 11 - February 29, 1972
S/AMA — Treating Today's Adolescent; by the Institute of Pa. Hosp. and U. of Pa.; 1½ hrs. per day; 1 day per week; 8 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March 16 - May 27, 1972
AMA — Principles and Techniques of Group Psychotherapy; at The Institute of Pa. Hosp.; by U. of Pa.; 2 hrs. ea. Saturday; 10 weeks; fee=$100; max. enrollment=15. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March 22 - May 24, 1972
AMA — Adolescence and the Youth Culture; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks; AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; March 22 - May 24, 1972
S/AMA — Advanced Marital Therapy — Treating Sexual Incompatibility; by the Institute of Pa. Hosp. and U. of Pa.; at Marriage Council of Philadelphia; 2½ hrs. per day; 1 day per week; 10 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Sayre; July 27, 1971—May 8, 1972
Rotating Specialty Seminar/Psychiatry; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 10 weeks; 10 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Scranton; September 29 - December 8, 1971

AMA— New Dimensions in Patient Care; at the Casey Inn; by The Institute of the Pa. Hosp., PMS and PAGP; 2 hrs. per day; 1 day per week; 12 weeks; 24 hrs. AAGP credit requested; fee=$25. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

OTHER COURSES
code

C—Continuous (Consecutive Days)
O—One Day or Less
PG—Postgraduate Traineeship
M—Multiple Sites (Circuit)

ALLERGY

February 7 - March 13, 1971; Philadelphia (repeat May 1 - June 23, 1972)

PG/AMA — Clinical Immunology Tutorial Course; at Hahnemann; 7-8 hrs. per day; 40 days; fee = $500. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

ARTHRITIS & RHEUMATISM

Continuous; Philadelphia

PG/AMA — Rheumatology Tutorial Course; at Hahnemann; 6-7 hrs. per day; 2 days per week; 4 weeks; fee = $150. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CARDIOVASCULAR DISEASE

Continous (2 or 3 weeks in each sub-section); Philadelphia

PG/AMA — Tutorial Courses; Fluid and Electrolyte Metabolism; Hypertension (Clinical & Laboratory); Dialysis; Cardio-Hemodynamics; Cardiac Care Unit; Electrophysiology; Vector-Electrocardiography and Cardiovascular Pharmacology; Atherosclerosis and Lipid Metabolism; Phono-Echo; Clinical Cardiology and Cardiovascular Surgery; at Hahnemann; 6, 7, 8, or 9 hrs. per day; 10 or 15 days; fee = $300 ea. sub-section. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

March 16-17, 1972; Philadelphia

C— Cardiopulmonary Resuscitation Instructors' Training Course; at Emergency Care Research Institute; by Pa. Heart Assoc. and Heart Assoc. of Southeastern Pa.; 7 hrs. ea. day; fee=$40. Contact Emergency Care Research Inst., 913 Walnut St., Philadelphia 19107.

March 21-22, 1972; Pittsburgh (repeat starting June 6, 1972)

C— Cardiopulmonary Resuscitation Instructors Training Course; at Pitt; by Pa. Heart Assoc. and Western Pa. Heart Assoc.; 7 hrs. per day; 2 days; fee=$40. Contact Div. of Cont. Educ., Pitt, 1022-H Scaife Hall, Pittsburgh 15213.

December 13-17, 1971; Philadelphia

C/AMA — High Blood Pressure, 1971 (26th Hahnemann Symposium); by Hahnemann; at Sheraton Hotel; 7 hrs. per day; 5 days; 35 hrs. AAGP credit approved; fee = $175. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

March 13-15, 1972; Philadelphia

C/AMA— Non-Invasive Technique in Evaluation of Cardiac Function; at U. of Pa.; by American Heart Assoc., Pa. Heart Assoc. and Heart Assoc. of Southeastern Pa.; fee (for Fellows)— $60. Contact Miss Carole Mintz, Dept. of Med. Ed., American Heart Assoc., 44 E. 23rd St., New York City 10010.

April 10-21, 1972; Philadelphia

C/AMA — Core Curriculum-Fundamentals and Applied Clinical Cardiology Seminar; by Hahnemann; 7 hrs. per day; 12 days; 84 hrs. AAGP credit requested; fee = $300. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

July 17-19, 1972, Philadelphia

C/AMA — Bedside Diagnosis of Heart Disease; by Hahnemann; 7 hrs. per day; 3 days; 21 hrs. AAGP credit requested; fee = $125. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CHEST DISEASES

Continuous (4 weeks in each sub-section); Philadelphia

PG/AMA — Tutorial Courses: Clinical Pulmonary Disease; Inhalation Therapy; Pulmonary Physiology; Respiratory Intensive Care; at Hahnemann; 7, 8, or 9 hrs. per day; 20 days; fee = $350. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

December 6-17, 1971; Philadelphia (Hahnemann)
March 14-25, 1972; Allentown Hospital

M/AMA — A Workshop in Respiratory Intensive Care; by Greater Delaware Valley RMP: 2 weeks; 5 days ea. week; 70 hrs. AAGP credit approved. Contact F. R. Johnston, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

February 28-March 10, 1972; Philadelphia

PG — Bronchoesophagology; at Temple; $350 fee; planned for chest physicians, thoracic surgeons, anesthesiologists and gastroenterologists. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

May 3-6, 1972; Philadelphia

C/AMA — Pulmonary Care in the Seventies (27th Hahnemann Symposium); by Hahnemann; at Marriott Motor Hotel; 5-6 hrs. per day; 4 days; 25 hrs. AAGP credit approved; fee = $175. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

May 25-27, 1971; Pittsburgh

AMA/C — Critical Care (Acute) Medicine; by Pitt and American College of Chest Physicians; at Pitt. Contact Esther BarCarmi, Registrar, Continuing Education Programs, American Coll. of Chest Physicians, 112 E. Chestnut St., Chicago, Ill 60611

EMERGENCY MEDICINE

November 14, 1971- Scranton

O— Emergency Medicine; at Sheraton Motor Inn; by Lackawanna Co. Med. Society and the Greater Delaware Valley RMP; 6 hrs. AAGP credit approved; no fee. Contact R.N. Shoemaker, Ph.D., Coordinator of Med. Educ., VA Hosp., 1111 E. End Blvd., Wilkes-Barre 18703.

February 7-18, 1972; Philadelphia (repeat May 2-13, 1972)

PG/AMA — Emergency Room Tutorial Course; by Hahnemann; 8 hrs. ea. day; 10 days; fee=$400. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

March 11, 1972; Hershey

O/AMA — Emergency Room Techniques; by PMS and Pa. Trauma Committee of ACS; at Hershey; 6 hrs.; min. enrollment=50; fee=$10. Contact PMS (Emergency Med. Service), 20 Erford Rd., Lemoyne 17043.

ENDOCRINOLOGY

March 6-31, 1972; Philadelphia

PG/AMA — Endocrinology and Metabolism Tutorial Courses; at Hahnemann, 7-8 hrs. per day; 20 days; fee=$350. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

GASTROENTEROLOGY

April 15, 1972; Hershey

O — Seminar on Gastroenterology; by PMS and Pa. Osteopathic Assoc.; at M.S. Hershey; 6 hrs. AAGP and ACGP credit requested; fee=$100; min. enrollment=20. Contact PMS (PMS-POA Seminar), 20 Erford Rd., Lemoyne 17043.

GENERAL MEDICINE

Continuous; Philadelphia

PG/AMA — Tutorial Courses: Basic Gener Medicine (7-8 hrs. per day; 60 days; fee=$70 Critical Care Medicine (8-9 hrs. per day; 10 day fee=$300) at Hahnemann. Contact Frederick Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 Broad St., Philadelphia 19102.

As Requested, 1971; Philadelphia

PG — Acute Care Medicine Fellowship (re training program for women physicians); by M.C of Pa.; 6 hrs. per day; 1 yr. duration. Contact Eth Weinberg, M.D., Assoc. Dean, MCP, 3300 Henr Ave., Philadelphia 19129.

As Arranged; Philadelphia

PG — Preceptorship for Practicing Physicians at M.C.P.; may be arranged as 1 day per week i 16-week block @ $200-$300, 2 weeks @ $250, weeks @ $375 or 1 month @ $500; program available in Int. Med., Ob. & Gyn., Pediatrics, Psy chiatry, Radiology and Surgery. Contact Gerald H Escovitz, M.D., Dir. Regional Medical Program Ac tivities, M.C.P., 3300 Henry Ave., Philadelphi 19129.

Third Wed. ea. mo.; Aliquippa-Rochester Hospi tals (rotation)

Fourth Thurs. ea. mo.; Altoona Hospital
First Tues. ea. mo.; Greensburg (Westmoreland Hosp.)
First Thurs. ea. mo.; Johnstown (Conemaugh Valley Mem. Hosp.)
Second Tues. ea. mo.; Natrona Heights (Allegheny Valley Hosp.)
Last Mon. ea. mo.; Uniontown Hospital
First Wed. ea. mo.; Washington Hospital

M — Diagnosis and Management of Hyperten sion; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin F Shapiro, M.D., Project Dir., 501 Flannery Bldg 3530 Forbes Ave., Pittsburgh 15213.

January, 1972; Allentown
January, 1972; King of Prussia

M — The Physician and Addictive Disease; by PMS, PAGP, Pa. Dept. of Health and Pa. Dept. of Welfare; 8 hrs. AAGP credit requested; min. enrollment=10, fee=$10. Contact PMS, 20 Erford Rd., Lemoyne 17043.

December 13-17, 1971; Philadelphia

C/AMA — High Blood Pressure - 1971; by Hahnemann; at Sheraton Hotel; 8 hrs. ea. day; 4½ days; 35 hrs. AAGP credit requested; $125 fee. Contact Mrs. Sage Cordell, Asst. Dir., Cont. Educ., 230 N. Broad St., Philadelphia 19102.

May 4-6, 1972; St. Davids

C — Annual Main Line Conference of Bryn Mawr Hosp.; at Treadway Inn; 2½ days; 15 hrs. AAGP credit approved; fee=$35. Contact Theodore J. Berry, M.D., DME, Bryn Mawr Hosp., Bryn Mawr 19010.

INTERNAL MEDICINE

January 3-7, 1972; Philadelphia

C/AMA — Workshops in the Physiology, Pathophysiology and Diagnosis of Disorders of Electrolyte and Acid-Base Metabolism; by Amer. Coll. of Physicians; at Hospital of the U. of Pa.; Fee: Members and F.A.C.P. =$80, non-members = $125, candidate members and ACP Latin American Fellows = $40. Contact Registrar, Postgraduate Courses, Amer. Coll. of Physicians, 4200 Pine St., Philadelphia 19104.

March 20-24, 1972; Philadelphia

C/AMA — Specifically Treatable Diseases (Emphasizing Pathophysiology and Early Clinical Findings); by Amer. Coll. of Physicians; at Pennsylvania Hosp. and U. of Pa.; Fee: Members and F.A.C.P.=$80, non-members=$125, candidate members and ACP Latin American Fellows=$40. Contact Registrar, Postgraduate Courses, Amer. Coll. of Physicians, 4200 Pine St., Philadelphia 19104.

MALIGNANT DISEASE

November 1-26, 1971; Philadelphia (repeat February 7 - March 3, 1972, and April 3-28, 1972)

PG/AMA — Hematology and Medical Oncology Tutorial Course; at Hahnemann; 8-9 hrs. per day;

20 days; fee=$400. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

NEPHROLOGY

June 5-7, 1972; Philadelphia
C/AMA — Nephrology for the Practicing Physician; by Hahnemann; at Holiday Inn; 7 hrs. ea. day; 3 days; 21 hrs. AAGP credit requested; $125 fee. Contact Mrs. Sage Cordell, Asst. Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

NEUROLOGY

Continuous (12 weeks in each sub-section); Philadelphia
PG/AMA— Tutorial Courses: Clinical Neurophysiology (2 hrs. per day; 1 day per week; fee=$250); Neuropathology; Adult Neurology; Pediatric Neurology (5-6 hrs. per day; 60 days; fee=$1,000); at Hahnemann. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

PATHOLOGY

November 19-20, 1971; Philadelphia
C/S/AMA— Cytology; at Jefferson; 7 hrs. per day; 14 hrs. AAGP credit requested; minimum registration=25; maximum registration=50; fee=$200. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PEDIATRICS

April 13, 1972; Hershey
O — Maternal and Child Health Institute; by PMS and Pa. Dept. of Health; at M.S. Hershey; 7 hrs. AAGP credit requested; min. enrollment=100, fee=$15. Contact PMS (Matern. Health), 20 Erford Rd., Lemoyne 17043.

May 9-12, 1972; Philadelphia
C — Twenty-first Pediatric Postgraduate Seminar; by Temple; at St. Christopher's Hosp. for Children; 6 hrs. ea. day; 24 hrs. AAGP credit requested; $100 fee. Contact John B. Bartram, M.D., St. Christopher's Hosp. for Children, 2600 N. Lawrence St., Philadelphia 19133.

RADIOLOGY

Continuous; Philadelphia
PG/AMA — Cardiac Radiology; at Hahnemann; 8 hrs. per day; 5 days per week; 3 weeks; fee = $300. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

SURGERY

January 23-29, 1972; Pittsburgh
C — Concepts of Soft Tissue Surgery; at Mercy Hospital; by Amer. Academy of Facial Plastic and Reconstructive Surgery, Inc.; fee=$400 (special rates for residents and military personnel). Contact John T. Dickinson, M.D., D.Sc., G-2 M.D. Bldg., 1501 Locust St., Pittsburgh 15219.

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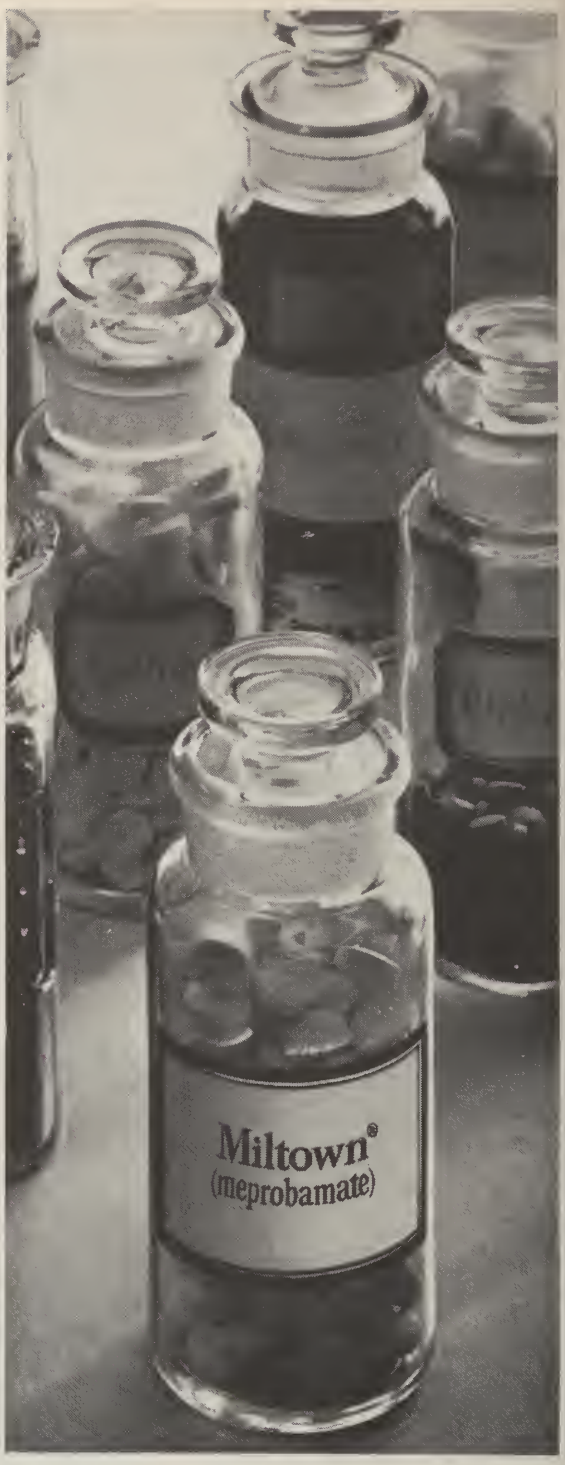

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obituaries

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Thomas H. Llewellyn**, Philadelphia; University of Pennsylvania School of Medicine, 1912; age 87; died August 10, 1971. He was a general practitioner for more than 60 years. His wife, one brother, and three sisters survive him.

○ **Edwin R. Raymaley**, Pittsburgh; College of Physicians and Surgeons, Baltimore, Md., 1904; age 93; died August 8, 1971. He is survived by a daughter and a son, Edwin R. Raymaley, Jr., M.D., Plattsburgh, N.Y.

○ **Oscar E. Salter**, Fort Lauderdale, Fla.; Medico-Chirurgical College of Philadelphia, 1909; age 89; died August 15, 1971. Dr. Salter had been a practicing physician in Shamokin. A son and a daughter survive him.

○ **Albert G. Santarelli**, West Chester; University of Pennsylvania School of Medicine, 1961; age 36; died August 1, 1971. He was a member of the American College of Surgeons and of the American Academy of Orthopaedic Surgeons. In addition to his wife, a daughter, two sons, three brothers, and a sister survive him.

○ **Markley R. Seibert**, Reading; Hahnemann Medical College, 1928; age 68; died July 27, 1971. A daughter, a son, a brother, and a sister survive him.

○ **James M. Steele**, Lehighton; Jefferson Medical College, 1933; age 63; died July 31, 1971. He was chief of staff and chief of surgery at Coaldale State General Hospital and was a fellow in the American College of Surgery. His wife and two sons, one of whom is John E. Steele, M.D., Lehighton, survive him.

○ **Alfred G. Zangrilli**, Pittsburgh; Jefferson Medical College, 1955; age 44; died August 4, 1971. He is survived by his wife, three daughters, and a son.

○ **Joseph L. Bryant**, Washington; Western Reserve University School of Medicine, 1941; age 59; died September 12, 1971. He served on the faculty of Washington Hospital School of Nursing and was physician at Washington and Jefferson College for fifteen years. He is survived by his wife, two daughters, two sons, and two brothers.

○ **J. Loomis Christian**, Harrisburg; University of Pittsburgh School of Medicine, 1926; age 74; died September 5, 1971. He was a general practitioner, an instructor of nurses at Harrisburg Hospital, and chairman of medical examiners of the Dauphin County Board of Public Assistance. He is survived by his wife.

○ **Harold B. Cooper**, Scranton; Hahnemann Medical College, 1924; age 76; died August 20, 1971. His wife, a daughter, and a son survive him.

○ **Vincent D. Gallizzi**, Kingston; University of Naples, Italy, 1921; age 74; died September 12, 1971. He was a diplomate of the American Board of Otolaryngology, the American Board of Ophthamology, and of the International College of Surgeons. He is survived by his wife, three sisters, and a brother.

○ **John S. Gates**, Mt. Joy; University of Pennsylvania School of Medicine, 1934; age 64; died September 11, 1971. He was chief medical officer of the U.S. Armed Forces Induction Station, Baltimore, Md., post surgeon at the New Cumberland Army Depot, and chief medical officer at Fort Meade Personnel Center. He was also a Lt. Commander with the U.S. Public Health Service.

○ **James W. Gilchrest**, Greensburg; University of Pittsburgh School of Medicine, 1944; age 50; died September 21, 1971. Dr. Gilchrest belonged to the American College of Surgeons, the International College of Surgeons, and the American Society of Abdominal Surgeons. He was a diplomate of the American Board of Surgery. He is survived by his wife, his father, three daughters, and a son.

○ **Edward A. Haegele**, Mechanicsburg; Maryland Medical College, 1913; age 82; died August 25, 1971. He had been a practising physician and Cumberland County coroner since 1934. He was director of Seidle Memorial Hospital, Mechanicsburg. He is survived by a brother.

○ **Esquire Hawkins**, Ambler; Meharry Medical College, 1928; age 70; died September 9, 1971. He is survived by his wife, a step-daughter, and two sisters.

○ **William H. Hollis**, Annville; Hahnemann Medical College, 1966; age 33; died August 30, 1971. He was a general practitioner in Annville. He is survived by his parents, his wife, a daughter, a son, and a brother, Robert A. Hollis, M.D., Lebanon.

○ **James H. Householder**, Butler; University of Pittsburgh School of Medicine, 1944; age 51; died August 30, 1971. He had been pathologist at the Butler County Memorial Hospital for the past five years. He was a fellow of the American College of Pathologists and the American Society of Clinical Pathologists. He is survived by his wife, a daughter, and a son.

○ **Clark L. Markel**, Zelienople; University of Pennsylvania School of Medicine, 1937; age 60; died September 5, 1971. He is survived by his wife, a daughter, and a son.

Landislaus Adamkiewicz, Folcroft; Marquette University School of Medicine, 1916; age 77; died July 14, 1971. He had been a member of the American College of Physicians and Surgeons and a founding fellow of both the American Society of Clinical Hypnosis and the American Society of Pathologists. In addition to his wife, he is survived by a brother, Joseph Adamkiewicz, M.D., Marquette University, and two sisters.

Norman E. Anderson, Tucson, Ariz.; New York Medical College, 1954; age 41; died July 26, 1971. He was a psychiatrist in Philadelphia. He is survived by his wife, two daughters, a son, a brother, and his parents.

Robert R. Eidlemann, Freeland; Temple University School of Medicine, 1955; age 43; died April 5, 1971. He was a member of the American College of Radiology and the North American College of Radiology. Information concerning survivors is lacking.

Gloria Grzybicki, Bryn Mawr; Hahnemann Medical College, 1971; died August 9, 1971. She was an intern at Bryn Mawr Hospital. Besides her parents, she is survived by a sister and a brother.

Aaron L. Holstein, Broomall; University of Maryland School of Medicine, 1914; age 80; died April 2, 1971. He is survived by a niece.

Anesthesia in Patients with C-V Disease
Part 2

James M. Fenstermacher, M.D., director of anesthesiology, Reading Hospital, Reading, Pennsylvania, is questioned by William G. Leaman, Jr., M.D.

How can the internist prepare the patient with congestive failure for surgery?

Mild to moderately severe congestive heart failure is a common finding in the elderly patient who has a surgical problem. This *must* be treated with digitalis, diuretics, serum electrolyte balancing measures, etc., *before* surgery is attempted. Preparation can be accomplished in 8 to 24 hours, using I.V. therapy as required, guided by frequent laboratory determinations of serum electrolytes and other indicated studies.

Is steroid therapy of value pre- or postoperatively?

The use of intermittent steroid therapy in many elderly patients has created a serious pitfall for the anesthetist. He must suspect such problems and not hesitate to use a large single I.V. dose of steroid in the treatment of shock-like states, either during or after operation. The equivalent of one to three grams of hydrocortisone is an acceptable pharmacologic dose for this purpose.

How do you manage the anesthetic in patients who have undergone congenital, valvular, or coronary operations and now face an unrelated surgical procedure?

Many of these patients have an already embarrassed cardiac output, at best, so this must not be further jeopardized. Therefore, a narcotic-tranquilizer, nitrous oxide and tubocurarine sequence appears to offer the least disturbance to myocardial function. Again, many patients may be on some type of continuous anticoagulant therapy. Consequently, an increased tendency to blood loss must be expected and proper preparation for transfusion should be made in advance.

Should a cardiac patient undergoing surgery be constantly monitored?

Electrocardiographic and, if possible, intra-arterial blood pressure monitoring should be carried out before the patient is anesthetized. During the operation continuous electrocardiogram monitoring should also be done. If a ventricular arrhythmia appears (multiple premature ventricular contractions, ventricular tachycardia, or ventricular fibrillation), an intravenous infusion of lidocaine (1 mg per kilogram up to 100 mg), with or without DC countershock, is in order. For recurrent or lidocaine-resistant ventricular arrhythmias, propranolol in 1 mg increments to a total dose of 3 to 5 mg may be indicated.

What about the appearance of multiple atrial contractions or paroxysmal atrial arrhythmias?

Multiple atrial contractions or paroxysmal atrial tachycardia in these patients probably results from inadequate therapy for heart failure or digitalis-resistant myocardiopathy. Here treatment with lidocaine is usually unsuccessful while the use of propranolol may increase the intensity of the heart failure. However, in all these cases, it appears that a rapid, competent surgical operation conducted under the least anesthetic load consistent with good surgical conditions is well tolerated by most patients with heart disease with the exception of those suffering from an acute myocardial infarction.

Suppose a middle-aged patient who has an acute mitral insufficiency develops an urgent surgical problem. What is the anesthetic risk?

Certainly a mitral insufficiency presents an added risk, but these patients today can be offered relatively safe anesthesia.

What about the appearance of malignant hyperpyrexia in the pre- or postoperative patient?

This complication is fortunately rare. Our aim should always be prevention. Frequent temperature readings and constant monitoring should be routine. Since the mortality is high (70 to 75 per cent), operation should be postponed unless it is an emergency, when spinal anesthesia is the best choice.

When the patient gives a history of a previous myocardial infarction, does anesthesia increase the possibility of recurrence of this lesion?

Not necessarily, but if it does occur, it is usually about the third postoperative day. Therefore, electrocardiogram monitoring should be continued daily to try to detect even the "silent infarct" since narcotics and sedatives often may mask chest pain.

How long a time should elapse after an acute myocardial infarction before anesthesia?

Surgery of any type should be postponed, if possible, for six months. Among older patients today the surgeon is bound to have many who give a history of angina and previous myocardial infarction. Usually the more recent the infarction, the more likely it is that a second lesion of this type will occur during the first postoperative week.

William G. Leaman, Jr., M.D., edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.

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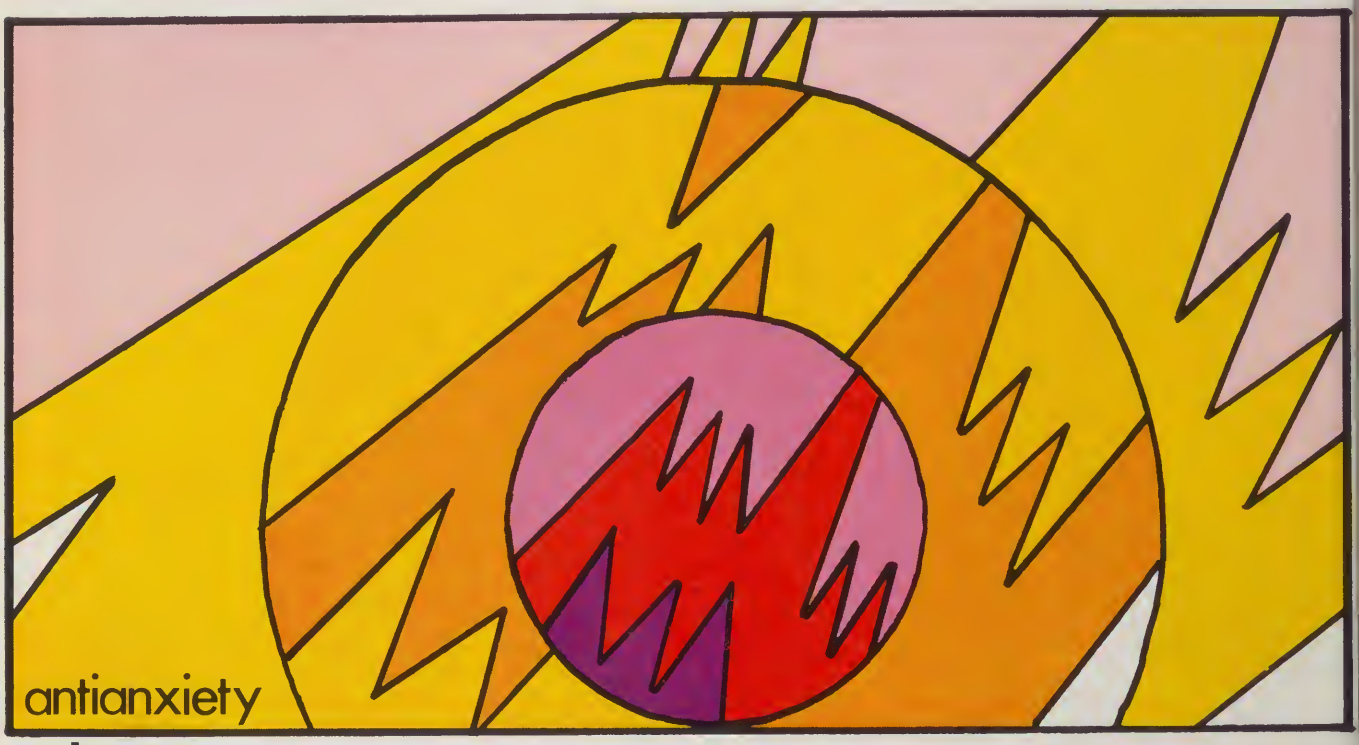

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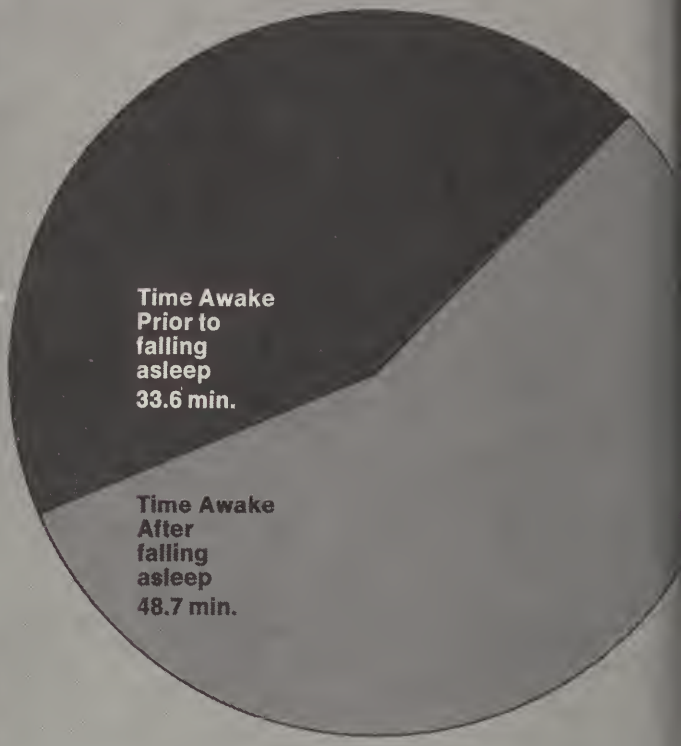
Dalmane is also relatively safe, as reported in clinical studies. Instances of morning "hang-over" have been relatively infrequent; paradoxical reactions (excitement) and hypotension have been rare. Dizziness, drowsiness, lightheadedness and the like were the side effects noted most frequently, particularly in the elderly or debilitated. (An initial dose of Dalmane 15 mg should be prescribed for these patients.)

References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

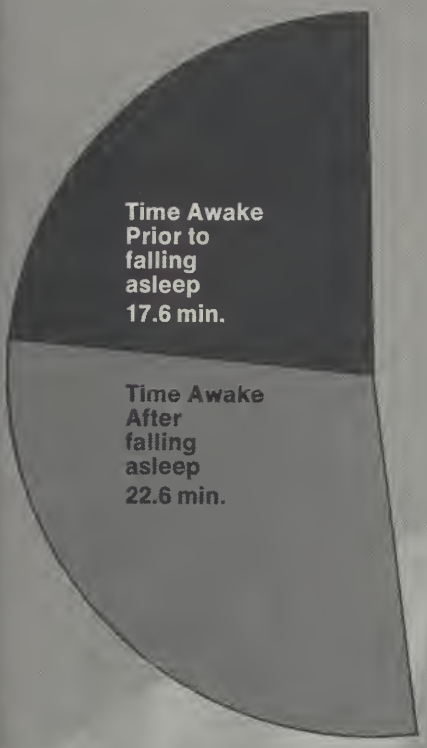
Before Dalmane (flurazepam HCl)



Measurements of sleep in the sleep laboratory are obtained with electroencephalographic, electro-oculographic and electromyographic recordings.

and slept through the night

On
Dalmane
(flurazepam HCl)



rage sleep laboratory measurements in cited studies

ameter	Before Dalmane	On Dalmane
e required to fall asleep	33.6 min.	17.6 min.
e time after onset of sleep	48.7 min.	22.6 min.
ber of wakeful periods after nset of sleep	12.2	8.4
l sleep time	420.0 min.	447.5 min.
l sleep percent	88.6	94.5

inical effectiveness as
oven in the sleep laboratory

Dalmane®
(flurazepam HCl)

e 30-mg capsule h.s.—usual adult dosage.
e 15-mg capsule h.s.—initial dosage for erly or debilitated patients.

Before prescribing Dalmane (flurazepam HCl), please consult Complete Product Information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

PENNSYLVANIA MEDICINE

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Journal of the Pennsylvania Medical Society

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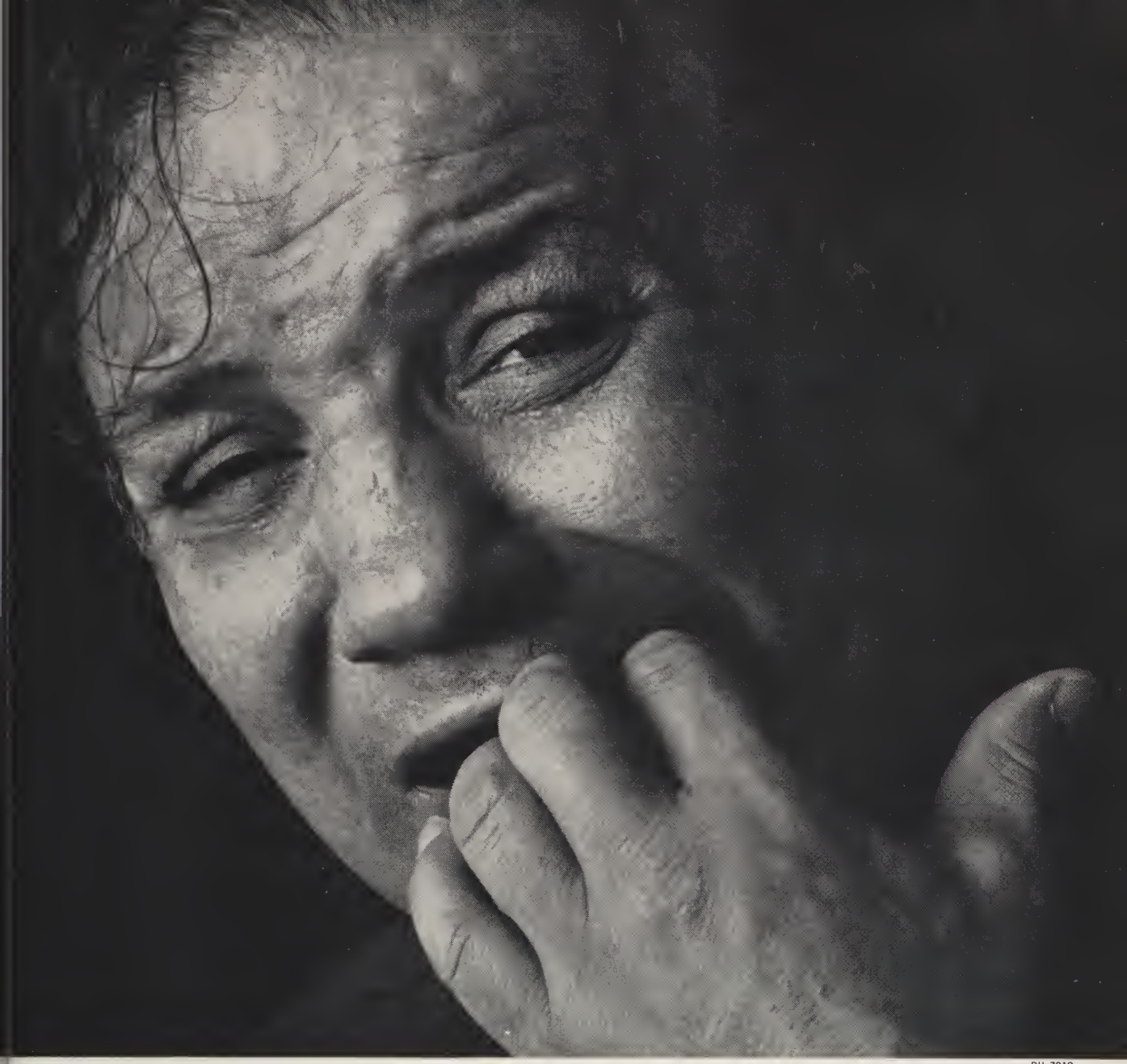

DU-7019

Who's afraid of the big bad enema?

We all are. But Dulcolax is the cure for enemaphobia. It can do almost anything an enema can – except look scary.

Just one suppository usually assures a predictable bowel movement in 15 minutes to an hour. Gone are the tubing, the "accidents", and the bruised egos associated with enemas.

For preoperative preparation, the combination of tablets at night and a suppository the next morning usually cleans the bowel thoroughly. Suppositories may also be particularly helpful when straining should be avoided as in postoperative care.

As with any laxative, abdominal cramps are occasionally noted. The drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable

bisacodyl

GEIGY PHARMACEUTICALS, DIVISION OF GEIGY CHEMICAL CORPORATION, ARDSLEY, NEW YORK 10502 UNDER LICENSE FROM BOEHRINGER INGELHEIM G. M. B. H.

An epidemic that's striking home...

gonorrhea

There were more than 16,000 reported cases of gonorrhea in the Keystone State last year... almost 75 percent of them in Philadelphia alone

In Pennsylvania... and everywhere else... a new alternative

NEW Trobicin®

SPECTINOMYCIN DIHYDROCHLORIDE, PENTAHYDRATE, UPJOHN

single-dose treatment for intramuscular use only

a chemically distinct antibiotic indicated specifically for treatment of acute gonorrhea:
in the male–acute urethritis and proctitis
in the female–acute cervicitis and proctitis
when due to susceptible strains of *N. gonorrhoeae*

High cure rate:* 96% of 571 males, 95% of 294 females (Dosages, sites of infection, and criteria for diagnosis and cure are defined on page 3 of advertisement).

Assurance of a single-dose, physician-controlled treatment schedule

No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed

Active against most strains of Neisseria gonorrhoeae *in vitro* (M.I.C. 7.5-20 mcg/ml)

A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing).

*Data compiled from reports of 14 investigators.

NOTE: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

For full prescribing information, including contraindications, warnings and precautions, please see last page of this advertisement.

pjohn

e Upjohn Company, Kalamazoo, Michigan 49001

Trobicin and the gonorrhea challenge

An accelerating epidemic—a decelerating susceptibility to penicillin

Gonorrhea is now the most prevalent reported communicable disease in the nation. The estimated number of new cases of gonorrhea in the United States exceeded two million for the first time in 1970. To compound the problems, strains of *N. gonorrhoeae* increasingly resistant to penicillin and other antibiotics are appearing throughout the country. Schedules of treatment which were effective only a few years ago now result in a significant percentage of treatment failure. *In vitro* studies have demonstrated that resistance of *N. gonorrhoeae* may also develop to Trobicin.

Thus, while aqueous Procaine Penicillin G remains the drug of choice for the majority of patients, the need for a non-penicillin, intramuscular antibiotic for acute gonorrhea in the male and female is abundantly clear. Such an antibiotic should be effective following a single intramuscular injection —and it should not demonstrate cross-resistance with penicillin

Trobicin—a new alternative specifically for the treatment of acute gonorrhea

Trobicin is indicated in the treatment of acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

High cure rates: 96% of 571 males, 95% of 294 females

No allergic reactions occurred in patients with an alleged history of penicillin hypersensitivity when treated with Trobicin, although penicillin antibody studies were not performed.

Chemically distinct

Trobicin is structurally not related to any other antibiotic commonly used to treat gonorrhea.

The assurance of a single-dose, physician-controlled treatment schedule

Intramuscular injections should be made deep into the upper outer quadrant of the gluteal muscle.

Adult male: Single 2 gram dose I.M. in acute gonorrheal urethritis. Single 4 gram dose I.M. (should be divided between two gluteal injection sites) in gonorrheal proctitis and in patients being re-treated after failure of previous antibiotic therapy. In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams intramuscularly is preferred.

Adult female: Single 4 gram dose I.M. (should be divided between two gluteal injection sites) in acute gonorrheal cervicitis and proctitis.

Safety for use in pregnancy has not been established, nor has safety for use in infants and children.

Clinical Results with Single-Dose Treatment, Intramuscularly* (Data compiled from reports of 14 investigators**)

	Dosage	Number of Patients	Number Cured	Percent Cured
Adult Males: Gonorrheal urethritis	**2 grams** **4 grams**	**475** **96**	**457** **93**	**96%** **97%**
Adult Females: Gonorrheal cervicitis	**4 grams**	**294**	**280**	**95%**

Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin medium in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included in the table above.

The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

*4-gram doses were injected in two gluteal sites.

**Medical Research Files, The Upjohn Company

a chemically distinct antibiotic indicated specifically for treatment of acute gonorrheal urethritis and proctitis in males and cervicitis and proctitis in females when due to susceptible strains of *N. gonorrhoeae*

new Trobicin®

STERILE SPECTINOMYCIN DIHYDROCHLORIDE PENTAHYDRATE, UPJOHN

single-dose treatment for intramuscular use only

erile Trobicin®
pectinomycin dihydrochloride penta-
ydrate)—For Intramuscular injection:
gm vials containing 5 ml when reconsti-
ed with diluent. 4 gm vials containing
ml when reconstituted with diluent.

n aminocyclitol antibiotic active *in vitro* gainst most strains of *Neisseria gonor-*oeae (MIC 7.5 to 20 mcg/ml). Defini-e *in vitro* studies have shown no cross sistance of *N. gonorrhoeae* between obicin and penicillin.

dications: Acute gonorrheal urethri- and proctitis in the male and acute onorrheal cervicitis and proctitis in the male when due to susceptible strains *N. gonorrhoeae.*

ontraindications: Contraindicated in atients previously found hypersensitive Trobicin. Not indicated for the treat-ent of syphilis.

arnings: Antibiotics used to treat gon-rhea may mask or delay the symp-ms of incubating syphilis. Patients ould be carefully examined and onthly serological follow-up for at least months should be instituted if the diag-sis of syphilis is suspected.

afety for use in infants, children and egnant women has not been estab-hed.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae.*

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.

Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female— single 4 gram dose (10 ml) intramuscularly.

How supplied: *Vials, 2 and 4 grams —with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.

Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae.*

Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

For additional product information, see your Upjohn representative or consult the package insert. MED-B-1-S (LWB)

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

IT'S NO SECRET...
that the Pennsylvania Medical Society's professional liability insurance program is off to a flying start...

with YOU aboard, its success will be assured!

The Pennsylvania Medical Society is gratified and encouraged by the extraordinary success to date of the Society-sponsored Professional Liability Insurance Program which went into effect June 1, 1971. The unfavorable insurance market conditions which prompted the Society's sponsorship of such a program, including arbitrary cancellations, non-renewals or refusals to write newly licensed physicians, still exist. Under the circumstances, it is still in the best long-term interests of *all* PMS members to transfer their individual malpractice insurance coverage as promptly as possible.

The PMS Program is completely "doctor-oriented," having been designed to provide *long-term* coverage and adequate limits at the best possible cost, in addition to giving the Society, on behalf of its members, an opportunity to participate in all important policy-making, administration and loss prevention aspects vital to the Program's success.

The program is being underwritten by the Argonaut Insurance Company, a well established, "A+AAAA" rated casualty insurance carrier with assets in excess of $180,000,000 and considerable experience in the medical liability field. The exclusive, full-time administrator of the program is Parker & Co. Inc. of Pennsylvania, one of the country's leading insurance brokerage firms.

In review, the major points of the program are:

1. The Pennsylvania Medical Society has entered into an agreement with the Argonaut Insurance Company to administer the program through Parker & Co., Inc. of Pennsylvania.
2. The Argonaut Insurance Company will be bound to make this program available for a *minimum of five years. No* other carrier has offered such an agreement.
3. The Society participates through a Professional Liability Insurance Commission consisting of twelve members. The Commission will be the ultimate authority in appeals stemming from disputes between member insureds and will work in close conjunction with the local district committees.
4. No member's application will be declined except by the *joint decision* of the PMS Commission and the Argonaut Insurance Company.
5. Full liability coverage of $100,000 for each claim with an annual aggregate limit of $300,000 with excess limits up to $1,000,000 available. Coverage *is* available for interns, residents and physicians' and surgeons' assistants.
6. Rates are competitive with other major writers of professional liability insurance in Pennsylvania.
7. There is no requirement that a member purchase ancillary insurance coverages (homeowners, auto, etc.) in order to participate.

This program offers PMS members a unique opportunity to stabilize their professional liability insurance coverage on a long term basis. However, a broad based, high degree of membership involvement is essential to make this program a success. Please fill out the coupon indicating your interest in participating in the PMS endorsed program when your present coverage expires.

Argonaut Insurance Companies

Mail to:
Parker & Co., Inc. of Pennsylvania
1616 Walnut Street, Philadelphia, Pennsylvania 19103
Attention: Mr. A. John Smither, Vice President

Name _____

Office Address _____

Telephone No. _____

Medical Specialty _____

Date your professional liability insurance expires _____

Present Carrier _____

I am interested in participating in the PMS Professional Liability Insurance Program. Please send me an application. ☐

An insurance program sponsored and supported by the PMS.

Welfare Department Rescinds 72-Hour Review

The Department of Public Welfare has reported to Society officials that it has rescinded the 72-hour hospitalization review requirement of its controversial Memorandum 16. The action followed meetings with Pennsylvania Medical Society representatives. Apparently the other provisions of Memo 16 are unaffected. The change is being announced in detail in a Medical Assistance bulletin being mailed by the Welfare Department.

DR. MARSHALL TESTIFIES The House Ways and Means Committee has concluded public hearings on National Health Insurance and is holding closed sessions from which will come the committee's bill for House consideration. Matthew Marshall, Jr.,M.D., of Pittsburgh, a member of the PMS Council on Medical Service and chairman of the Medical Care Appraisal Project, testified during the final week of hearings and urged that the "Bennett Amendment," calling for establishment of Professional Standards Review Organizations, be included in the legislation. Dr. Marshall's testimony supported the AMA Medicredit plan. It explained the Society's research and development project as a means to establish comprehensive, computerized claim processing, medical audit, and utilization review, with the aim of "improving the productivity of the health dollar and the quality of health services." Dr. Marshall also testified at Insurance Department hearings in Pittsburgh on a request for a rate increase by Blue Cross of Western Pennsylvania. John Helwig, Jr., M.D., of Philadelphia, represented the State Society at similar hearings in Harrisburg. Both urged that maintenance of high quality in hospital care must not be overlooked in an effort to cut costs.

STATE ATTACKS SICKLE-CELL ANEMIA The first state-funded attack on sickle-cell anemia was authorized recently when Governor Milton J. Shapp signed into law an appropriation bill providing $77,630 to fight the disease. The Department of Health will establish a program of detection, treatment, counseling, public education and research, which will operate out of Children's Hospital in Philadelphia. Congress is considering legislation that would add federal support to the program.

METHADONE USE SUPPORTED The Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs have testified in support of the use of Methadone in maintenance treatment of heroin addiction in hearings before the House Commerce Committee's subcommittee on health and environment, but cautioned that strict controls must be maintained to prevent diversion and misuse.

VITAMIN C AND THE COMMON COLD

Physicians can be prepared for a new bombardment of questions on the use of vitamin C to prevent colds. December 1 was the publication date of a book written for laymen by Edme Regnier, M.D., entitled "There is a Cure for the Common Cold." The book advocating vitamin C use follow publication in "Review of Allergy" in 1968 of the doctor's scientific findings based on ten years of research. There are growing questions --pro and con-- about the use of vitamin C.

MANPOWER BILL SENT TO PRESIDENT

A conference committee of the U.S. Senate and House of Representative has reached agreement on provisions for the Comprehensive Health Manpower Training Act of 1971, and it has been signed by President Nixon. The act authorized appropriations of $2.9 billion over fiscal years 1972, 1973 and 1974 for health manpower programs. Included are grants for the construction of research and teaching facilities including new schools of medicine, institutional support, special project grants and contracts, aid for schools in financial stress, student loans and special grants for training in family medicine.

NEW LAWS CHANGE NAME

Governor Shapp has signed into law three bill amending where necessary laws already in existence in order to change the name of the State Anatomical Board to the Humanity Gifts Registry. The next step is expected to be legislation establishing the Registry as a clearing house for anatomical gift body parts for transplant as well as whole bodies. Until such legislation can expand the function of the Humanity Gifts Registry, the Pennsylvania Medical Society has established through the Council on Public Service a Humanity Gifts Center to answer questions, distribute donor cards and conduct a general educational campaign on the need for bodies and body parts. PMS members may obtain further information by contacting the Humanity Gifts Center, 20 Erford Rd., Lemoyne 17043.

AWAITING THE SIGNATURE

Both houses of the Legislature now have passed a bill permitting physicians to treat consenting minors who have venereal disease without parental consent and exempting them from liability for properly administering appropriate treatment. It becomes effective as soon as the governor signs it.

SPEAKERS' SEMINAR PLANNED

A two-day workshop for officers of the State Society and members of its Speakers Bureau has been planned for PMS headquarters Dec. 8 and 9. In addition to speaking techniques, the seminar will provide background on the various national health insurance plans pending in the Congress.

DR. SIGEL ACTING PRESIDENT

Bernard Sigel, M.D., dean of the Medical College of Pennsylvania, became acting president of that institution December 1. He succeeds Marion Fay, Ph.D., who retired. Dr. Sigel has been on the faculty since 1960.

DR. DAVIS APPOINTED

J. Mostyn Davis, M.D., Shamokin, past president of the Pennsylvania Academy of Family Practice and active in PMS affairs, has been appointed vice-chairman of Susquehanna Valley Regional Medical Program's Regional Advisory Group by Chairman George C. Williams of Wellsboro.

Dr. Masland puts dues increase in perspective

In order to clarify the philosophy and make known the hard facts studied by the PMS Board of Trustees and its Finance Committee prior to their recommending a dues increase in 1972, the staff of PENNSYLVANIA MEDICINE interviewed Chairman of the Board David S. Masland, M.D., at his Carlisle office. Dr. Masland formerly was Board vice-chairman and chairman of the Finance Committee. He was elected chairman of the Board to fill the unexpired term of Park M. Horton, M.D., New Milford, who was elected president-elect of the Society at the 1971 Annual Session.

"Dues increase" is a dreaded term in the association world. What made you decide to go for one in 1972?

"We were confronted with a very basic financial problem— that of balancing the budget. Based on current income, we would have run $121,569 in the red."

I understand that the Pennsylvania Medical Society receives reimbursement from the federal government for the management services it performs on behalf of the Susquehanna Valley Regional Medical Program. Does your projected deficit figure for 1972 include reimbursement from the federal government?

"Unfortunately, it does. Without that reimbursement the projected deficit for 1972 would run closer to $225,000."

DR. MASLAND

Why did you decide to go for a $25 dues increase— an increase of 33-⅓ percent? Couldn't you have made it a smaller amount and still balance your budget?

"You have to put this in perspective. The last time we had a dues increase was in 1964. At that time we went from $60 to $75 dues, an increase of 25 percent. In the years since we experienced an inflation rate of 32.8 percent, so actually during the period since we last increased our dues, the Society has experienced a decrease in purchasing power of roughly the amount of dues increase which we asked for. Now it is true that we could have balanced the budget without asking for $25 dues increase *if* we could really count on the projected federal reimbursement for management of SVRMP. But the rate of reimbursement for these services has been going down; it is our understanding that the government is looking very carefully at the accounting formulas which are used to determine the rate of reimbursement and that it is possible that rate will decrease again. I also have— and I believe several other members of the Board have the same feeling— reservations about the Society becoming dependent on federal dollars in order to balance its budget. I question whether or not we are really going to maintain our independence and integrity in such a situation. So it has been my philosophy all along, even from the beginning days of our involvement in the Regional Medical Program, that the Society should not lean on reimbursement from the federal government. I would like to see us maintain our complete and total financial independence of the federal government. The dues increase makes that possible."

There's a wage-price freeze on. This dues increase was voted by the House of Delegates in October in the middle of the wage-price freeze. How was that possible?

"It's quite simple. The dues increase will not be effective until January 1, 1972— after the expiration of the wage-price freeze. Of course, by that time we will have examined the guidelines governing the post-freeze wage-price climate of the country and we will know whether or not we have the right to invoke the entire $25 dues increase which was authorized by the House. The guidelines may not permit us to go for the full amount. In that case we will tailor the dues increase to fit the specifications of the guidelines. This would be unfortunate if this were the case, since this is our first dues increase in eight years and, as I said, we've suffered the effects of heavy inflation during that period."

You mean that the dues increase could actually turn out to be less than the $25 authorized by the House of Delegates?

"Yes, that's right. It's possible. We'll have to look at the guidelines and be

(Continued on page 12)

governed by them. What we sought and got from the House of Delegates in Pittsburgh, without a dissenting vote, was the authorization to go to a $25 dues increase. That was the amount the Finance Committee, the Board of Trustees, and the House of Delegates felt would give the Society the kind of fiscal stability which it should have.*"

I understand the Society has a contingency reserve fund. Why didn't the Board use this to balance the budget in 1972?

"That could be done. That's true. There's $423,155 in our contingency reserve fund but, frankly, that doesn't make sense. If we use this money to meet everyday operating costs it wouldn't be a contingency reserve fund. Generally accepted business practice says that an association should have sufficient financial strength to withstand an unforeseen decline in income or increase of expenses. That's what a contingency reserve fund is about. It's also the kind of fund that you use when you are suddenly confronted with the problem of financing emergency-type projects occasioned by unexpected developments, say, for example, some sort of legislative problem which we haven't anticipated. That's the way a contingency reserve fund is used. For that reason, the Finance Committee didn't think it was wise to use these funds to pay the electric bill and so on. Because if you did that, you wouldn't have money left to meet a real emergency."

What caused the projected deficit in 1972? Is it an increase in expenses or programs?

"Primarily, it is because of inflation. As I mentioned, we haven't had a dues increase in eight years and there has been an awful lot of inflation in that period. However, the Society is moving ahead on some very critical programs. The one that comes immediately to mind is the Medical Care Foundation which is the Society's response to holding down medical costs. We are in the developmental phase at this point but we have to be in a position to give it the kind of financial support that it needs to succeed. This is one of the most exciting things that the Society has done, in my opinion, in the last decade or so. There is also a new institute for postgraduate medical education which the Society is forming. The institute will get into pinpointing physicians' postgraduate developmental needs and into the problems of coordinating postgraduate education among the many institutions which are in that field. This also is a critical need. So it is a combination of two things— we're on the brink of a whole new era in medicine, the way it is going to impact on the economics of the country, the priority that the people in the country are giving it, the kind of dollars that the federal government is ready to spend on health care. There are going to be changes in the delivery of health care, obviously, there's going to be a new emphasis on controlling the quality of care, and the Society has to be ready and, in fact, in the vanguard in developing these changes. Now to be in that sort of position, it's going to take money."

During this changeover that you're talking about, are we seeing a lot more staff people being hired?

"No. This is one of the things that I find personally gratifying. As a matter of fact, since 1963 our intramural staff has actually decreased by one. There are staff people assigned to the Susquehanna Valley Regional Medical Program who are paid out of federal funds but I'm talking about the people who are paid directly from dues dollars. That number has actually decreased by one. So I don't think that we can say that this money is being spent to hire more people to do more work which they have perhaps manufactured themselves through some insidious exercise of Parkinson's law."

How did the House of Delegates react to this request?

"Quietly. Frankly, I wish there had been more open discussion about it. My hope is that the delegates understood the reasons for the dues increase and will give the members back home the answers they need to support it. Either we did the job very well or the delegates were too stunned to react. My personal feeling is that all of the trustees were aware of the need and the reasons for the dues increase and in their District Councilor meetings they did a very able job of telling the delegates why this was necessary. I think another big factor in this is the fact that Bill Limberger (William A. Limberger, M.D., Chester County, Past President) during his year as president visited some 44 county medical societies. He explained the programs of the Medical Society, what we are doing. He also mentioned at several of those meetings that it looked as though we would have to go for a dues increase in order to balance the budget and expand in these critical areas which have been authorized by the House of Delegates. My hope is that the membership is better informed than ever before concerning the reasons for this dues increase."

Do you anticipate that the Society will lose very many members as a result of the dues increase?

"That's impossible to say. I don't think we'll lose any members who are really aware of what their Society is doing for them. We have a new malpractice insurance program, for example, which is guaranteed renewable for five years. No other society in the country offers a better program. We have a voice in the underwriting procedure. For the first time, the Society really has some input in guaranteeing its members malpractice protection. It takes the whimsicality out of the unstable insurance climate. That alone, in my opinion, is worth the cost of dues.

The benefits and the kind of efforts which the Society is undertaking on behalf of the membership are really startling in their scope. I feel that anyone who uses the benefits will pay his dues willingly. Those who take the time to find out what the Society is doing are proud to be members. You know, this is a good and useful organization. There are many around that are not so good and not so useful. But this is a good one. I think our members know it."

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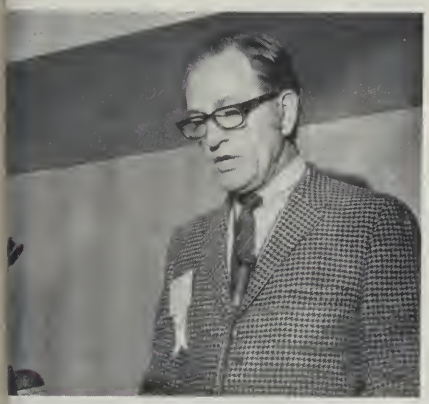
* *Since the interview, the Cost of Living Council has announced that the dues of nonprofit organizations are exempt under the Phase II guidelines of the President's Wage Price Control Program.*

Camera watches Scientific Assembly

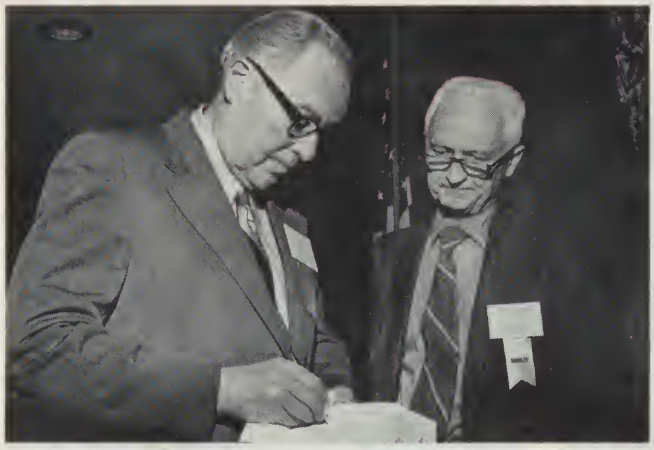
PROGRAMS FOR SPECIALTY SOCIETIES drew large audiences each day of the 1971 Scientific Assembly. To the left, below, is the panel which presented a program for the Pennsylvania Society of Internal Medicine on sexual adequacy and inadequacy. Left to right are: Drs. Paul Jay Fink, Philadelphia; Ephraim T. Lisansky, Baltimore, Md.; Jerome Chamovitz, Sewickley; and Albert M. Biele, Philadelphia. The top photograph to the left shows members of the panel which presented a program on preparation and transport of the injured for the Pennsylvania Committee on Trauma of the American College of Surgeons. They are, left to right, Drs. John H. Harris, Jr, Carlisle; L. Allan Erskine, Palmerton; William F. Bouzarth, Philadelphia and William E. DeMuth, Jr., Carlisle.



EDWARD J. KOWALEWSKI, M.D., Akron, left, past president of the American Academy of Family Practice, addresses the PAFP meeting on "The Emergency in the Delivery of Medical Care— Family Practice, America's Urgent Need." Below are shown members of the panel which discussed medicine's role in environmental health. Left to right are Drs. Joseph J. Schwerha, Finleyville; C. Merle Bundy, M.D., Pittsburgh; Robert E. Eckhardt, Linden, N.J.; Walter A. Lyon, Pennsylvania Department of Environmental Resources and Joseph A. Sataloff, Philadelphia.

MORE THAN A THOUSAND professionals in the health care field attended school last month at the PMS Scientific Assembly. A faculty of over 160 presented courses designed to meet specific needs of physicians and other health professionals in various fields. General theme of the assembly was "Clinical Therapeutics, 1971— Emergency Medicine." Shown above, left, is the audience at a session for nurses and allied professionals. At the right Vernon E. Wilson, M.D., HEW's administrator for Health Services and Mental Health Administration, addresses a general session on "Quality Medical Care."

PMS PRESIDENT GEORGE P. ROSEMOND, M.D., left, is shown directly below conferring with Vernon E. Wilson, M.D., administrator of HEW's Health Services and Mental Health Association, who spoke at one of the general sessions open to the public. In the photograph to the right, below, Robert H. Craig, Jr, PMS director of governmental relations, appears before the Pennsylvania Orthopaedic Society to discuss recent legislative and political proposals for orthopaedic surgeons. The photographs to the right show panelists who addressed various specialty meetings. At the top is the group which discussed aspects of geriatric medicine. Shown left to right are Joseph T. Bittenbender, M.D., Harrisburg; Joseph T. Freeman, M.D., Philadelphia; Paul J. Poinsard, M.D., Philadelphia; Nathan Sussman, M.D., Harrisburg and Raymond C. Wing, M.D., Easton. In the center are panelists who addressed themselves to emergencies due to pulmonary problems in a program prepared by the Pennsylvania State University College of Medicine, Hershey Medical Center. They are, left to right, Drs. Allen E. Yeakel, Frank G. Tyers, William Pierce and George T. Harrell, dean and director. The bottom of the three shots is of the panel which participated in the program prepared by the University of Pennsylvania School of Medicine on emergencies associated with renal and electrolyte disorders. They are, left to right, Drs. Donna K. McCurdy, Lee W. Henderson, and Martin Goldberg, with Session Chairman James A. Collins, M.D., Danville.



STUDENTS at one of the numerous programs offered for nurses and allied professionals at the 1971 Scientific Assembly are shown above. The four-day school attracted more than 1,000 physicians and allied health professionals.

Allegheny County opens second VD center

The steady rise in reported cases of gonorrhea and a growing number of patients seeking help at its Oakland clinic caused the Allegheny County Health Department to open a second venereal disease clinic recently on the North Side.

Harold H. Cashman, M.D., deputy director for medical services, says the facility will be equipped to perform the Darkfield test for early syphilis and that blood tests and cultures will be taken for laboratory analysis.

From January through August, there were 1967 reported cases of gonorrhea in the county, up 37 percent from 1,435 cases reported for the same months last year.

The number of patients attending the department's venereal disease clinic at 3441 Forbes Ave., Oakland, rose 27 percent from 8,482 patients who attended the clinic in the first three quarters of 1970 to 10,740 from January through August, 1971.

Dr. Cashman said, "Gonorrhea presents a special control problem because of its short incubation period— 3-5 days compared to 21-90 days for syphilis. It is difficult to reach the gonorrhea victim in time to prevent development and spread of the disease.

"The Health Department is making a special effort to control gonorrhea through careful interviewing of all males treated at the clinic and intensive follow-up of contacts."

PSU President Oswald appoints committee to choose new dean

A search committee to recommend candidates for dean of the College of Medicine of Pennsylvania State University to succeed George T. Harrell, M.D., who will retire in 1973, has been formed by PSU President John W. Oswald.

He has named John A. Waldhausen, M.D., professor and chairman of surgery, to head the committee.

Other members are Drs. C. Wayne Bardin, associate professor of medicine and chief of endocrinology; Elsworth R. Buskirk, director of the Human Performance Laboratory and professor of applied physiology at the University Park campus; Charles W. Hill, assistant professor of biological chemistry; Howard E. Morgan, professor and chairman of physiology; Nicholas M. Nelson, professor and chairman of pediatrics; and Mr. John M. Field, president of the Student Assembly of the College of Medicine.

A LINEAR ACCELERATOR, a new machine in radiotherapy, is shown above being delivered to the Hospital of the Medical College of Pennsylvania. The device propels particles in a straight line and receives successive increments of energy through the application of alternating potentials to a series of electrodes and gaps. It is said to be highly successful in treating cancer.

U. of Pennsylvania plans health center

The University of Pennsylvania will establish its first model urban health care organization at Graduate Hospital, staffed by faculty members of the school of medicine. The emphasis will be on keeping people well and out of the hospital, spokesmen said.

Scheduled to open during the summer of 1972, it will be operated by multi-specialty groups of doctors with the main emphasis on preventive medicine. Alfred Gellhorn, M.D., dean of the University of Pennsylvania Medical School and director of the University Medical Center, will be the coordinator.

Initially it will operate as a paid service facility providing round-the-clock service and utilizing the resources of both Graduate Hospital and the Hospital of the University of Pennsylvania. Later it is anticipated that alternate financing methods including prepaid group insurance may be incorporated in the program.

Faculty selected to establish the service and direct its operation are: Edward J. Stemmler, M.D., associate professor of medicine; Aaron D. Freedman, M.D., and Harry M. Woske, M.D., associate deans.

Artists urged to join

Physicians who have as a hobby the production of art in one of its many forms are being invited to join the American Physicians Art Association, which, as part of its activities, has a national exhibition including painting, sculpture, photography, and other art works produced by physicians. The exhibition is held each year in conjunction with the AMA annual meeting. For further information contact APAA President A.M. Gottlieb, M.D., 3801 Miranda Ave., Palo Alto, Calif. 94304.

More volunteer blood donors aim of educational plan

The American Association of Blood Banks (AABB) has announced a new public education program aimed at recruiting more volunteer blood donors. The aim is two-fold: to eliminate the high hepatitis risk from paid donors, and to decrease and eventually eliminate the commerical aspect of paying for blood, a practice which discourages voluntary donations.

William G. Battaile, M.D., AABB president, and Mrs. Bernice M. Hemphill, treasurer and chairman of the National Clearinghouse Program, estimate that 7 million pints of blood will be needed this year. They point out that only 3 percent of the 100 million potential donors in the country have given voluntarily.

The public education program is to be a joint effort of the AABB and the American Red Cross, each of which supply about half of the blood not purchased from blood banks. They are seeking help from the National Advertising Council, the American Medical Association, the American Hospital Association, the Blue Cross Association, the National Association of Blue Shield Plans, and the Health Insurance Council.

Daily pollution count issued by Allegheny

Allegheny County has begun issuing a daily pollution index on the 24-hour average concentration of sulphur dioxide and particulates in the air.

Automatic air monitoring stations located throughout the area collect data every three minutes which is sampled by sensors. The information is carried via telephone line to a computer at the air pollution control center.

The result is an air pollution index rated numerically from 0 pollution to 300, which is the emergency stage. Evaluated in terms of air quality standards set by the U.S. Environmental Protection Agency, the index is rated excellent, unsatisfactory, poor, or unhealthy, with a possible culmination at the emergency level. Any level below 25, which is the Federal Air Quality Standard for an annual average, is rated excellent. Any level above 200 will cause the Department of Health to issue warnings for susceptible individuals.

HAP announces election results

The Hospital Association of Pennsylvania has announced the election of new officers who will begin their terms of office on January 1, 1972. Bernard F. Carr, administrator of the Altoona Hospital, has been named president of the association, succeeding Edwin L. Taylor, Narberth, executive director of the Graduate Hospital of the University of Pennsylvania.

President-Elect will be Carl I. Bergkvist, president of Bryn Mawr Hospital. Vice-President will be Milton H. Appleyard, executive director of the Harrisburg Hospital, and Harold W. Luebs, administrator of Children's Hospital of Pittsburgh, will be the new treasurer.

James R. Neely will become executive vice president and director of the association. He will replace John Worman, who is retiring.

ACP schedules postgraduate workshops

The American College of Physicians will present postgraduate workshops in physiology, diagnosis, and treatment of electrolyte and acid base disorders on January 3-7, 1972, at the University of Pennsylvania School of Medicine.

Each half-day workshop will be preceded by a lecture in which an expert will discuss basic principles and new developments in the areas of acid-base metabolism, hyponatremia, hypernatremia, dehydration, edema, and specialized problems of fluid and electrolyte balance in diuretic therapy, renal disease, surgery, and endocrine diseases.

Thirty-five hours of credit is allowed toward the AMA Physicians' Recognition Award and for the membership qualification of the American Academy of Family Practice.

STUDENTS from Pennsylvania's medical schools met with representatives of the Council on Public Service and officers of the State Society during the recent Annual Session in Pittsburgh. Shown above are Richard G. Dudley, Jr., a Temple student who is a member of the SAMA Board of Trustees representing Region Three, and Margaret Mullins, president of the SAMA chapter at Medical College of Pennsylvania. Among topics discussed was an apprenticeship program for medical students which would permit them to work with doctors caring for patients early in their medical training.

Jefferson boasts rooftop helipad

Philadelphia's first hospital rooftop helipad at Thomas Jefferson University Hospital was recently dedicated with Peter A. Herbut, M.D., president of Thomas Jefferson University, delivering the keynote speech.

The $85,000 facility, which accommodates a 3,000 pound chopper ambulance, was underwritten by the Women's Board of the hospital. It will be used for serious emergency accident victims and for premature and high-risk infant transportation from community hospitals to Jefferson's regional treatment center for high-risk newborns.

Beaver County honors U.S. Surgeon General

U.S. Surgeon General Jesse Steinfeld became the first honorary member of the Beaver County Medical Society recently at a dinner held by the society for the benefit of the City of Hope.

The surgeon general is a native of Aliquippa and received his early education there. He received a plaque commemorating the event from John Shugert, M.D., county society secretary and master of ceremonies at the dinner.

PENNSYLVANIA MEDICINE special report

The Freeze Affects You!

LEIF C. BECK, LL.B.
Bala Cynwyd

President Nixon's wage/price controls have headed into "Phase II" with aspects affecting all practicing physicians. The initial (Phase I) rules, which were extremely inflexible and in many cases inequitable, have been carried over and will continue in effect until and unless modified by one of the Wage Board, the Price Commission, or the Health Services Cost Commission. What these commissions may decide, and when any such decisions might come into effect, is entirely uncertain.* As a result, physicians and their advisors should consider the Phase I freeze as still in effect, modified only by limited increases allowed by the initial Phase II rules; and they should keep well in mind what effects it will have on their practices.

No advisor can have all the answers to questions on this subject. The appropriate governmental units themselves have had extreme difficulty in laying down workable guidelines, with the unfortunate result that difficult questions have too often been met with a reply that they "will be studied further." Recognizing the difficulty, however, this article will attempt to describe those elements of wage/price controls which may affect medical practices.

1. **Fees and Other Prices:** The most obvious rule relates to medical fees. The Cost of Living Council has expressly stated that: "All medical fees for individual services, including those covered by medicare, are frozen." Similarly, fee schedules for services provided under medicaid programs are frozen. As a result, a physician's fee schedule cannot be any higher than it was during the "base period"— the 30 days from July 16 through August 14, 1971.**

On the other side of the coin, of course, the various fees, rents, and other charges paid by a practicing physician are likewise frozen to what they were during the base period. It should be noted that even if the physician's fee increase had been determined before the freeze began on August 15, or even if he had agreed to pay a higher charge or rent prior to the freeze, the increase would not be permitted if it had not taken sufficient effect before August 15.***

2. **Wages:**

(a) **On Employees Generally:** The general rule as to wages is just as obvious. Even if a nurse or other employee was regularly scheduled to receive a pay raise, it could not properly begin during the freeze. Nor can she be paid any bonuses, vacation pay, or fringe benefits which would increase her overall compensation package over the level in effect during the base period.

The initial Phase II permission of a 5.5 percent increase must also be kept in perspective. If, for example, an employee has already had that much of a pay raise, it appears that he or she cannot be increased again (not even by 5.5 percent) until the anniversary of the prior raise. This will presumably become clearer as rulings are issued to interpret the new guidelines.

Several of my clients have raised a special problem. They had hired new employees at lower rates of pay for the first few months with the understanding that they would remain at the lower levels only while the employees are learning their new jobs. The question is simply whether the rate of pay may properly be raised when an employer has decided to accept the person as a permanent employee. The Cost of Living Council has ruled that such a pay raise may be granted provided the initial test period did not exceed three months and was an established practice of the employer. I have encouraged my clients who fit this situation to expressly mark "probationary" or a similar designation, on any new employee's payroll sheet if they follow such pay policies.

(b) **On Incorporated Physicians:** The freeze plays particular havoc with professional corporations. As demonstrated below, it is serious enough that a physician with even one full-time employee should probably defer incorporating until the situation clears up somewhat.

Since the controls apply to employee fringe benefits as well as to "direct" wages, and since a new professional corporation is considered the "successor" to the old private practice, the total compensation of a nurse or other employee cannot be higher after the incorporation than it was during the base period. A physician normally chooses to incorporate in order to adopt a more generous fringe benefit retirement plan, which under tax law must apply to his employees in the same manner as to himself. This

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* *At this writing, the initial Phase II guidelines have been issued. They would permit wage increases of 5.5 percent annually. Professional fees may be increased only enough to offset any wage or other cost increases. The term "freeze" refers in this article to the controls under these new guidelines.*

** *The regulations contain an alternate measurement of the price, rent, wage, etc. level in effect on May 25, 1970, the date the basic presidential authority was enacted.*

*** *Despite the Phase II permission of what might be a minimal fee or price increase, the initial guidelines permit no increase in rents.*

benefit for his employees would, however, violate the freeze by increasing their total compensation packages (straight salary plus fringe benefits) above their pre-incorporation levels. Hence, since he might not be permitted to adopt such favorable retirement plans the physician with any employees would usually be unwise to incorporate.

Most experts believe the freeze on fringe benefits will be one of the first items to be removed. No one can, however, confidently predict when and in what form exemption will be granted. Although such an exemption will generally revive the desirability of incorporating (*if* it is otherwise economically and practically justified), I am strongly against one's incorporating until it has in fact been granted. Not until then can he assure that the desired benefits will be available.

In addition to discouraging new incorporations, the freeze is playing havoc with existing professional corporations simply by preventing physicians from raising their *own* salaries. While an incorporated practice is all too often discovered to be producing more net income than had been predicted for the fiscal year, the traditional solution was simply to raise the physician's salary level (or pay him a bonus, which involved a greater tax risk). The increased compensation would lower the corporation's taxable income and thus avoid a double tax situation. Since all wages, including the physician's own compensation, are now frozen, however, he cannot resort to such self-serving adjustments. Thus, the incorporated physician may find his additional earnings "locked in" his corporation at considerable tax loss.

There are other "horror stories" of freeze effects on professional corporations. Consider, for instance, the two-man practice in which the younger physician's share of income was scheduled to increase from 40 percent to 50 percent on October 1, 1971. Since the practice was incorporated, his salary was simply scheduled to rise accordingly on that date. The freeze has made him most unhappy. Consider also the physician or physicians who incorporated on January 1, 1971 and delayed adopting retirement plans until near the year's end— a generally sound procedure. The freeze would now make such plans illegal, thus locking into their corporations the thousands of dollars earmarked for retirement.

Physicians who are locked into these dilemmas have only limited solutions, but their advisors' immediate and extended attention may make the best of the bad situations. Armed with the freeze regulations and daily rulings, and using other tax planning devices sometimes available, they may use their ingenuity to save the day if given as much time and information as possible.

3. **Enforceability:** Some people have suggested that the government will not detect individuals' violations. In addition to a basic obligation of obeying valid laws, the physician may find the risk of discovery far greater than indicated. Similarly, the statutory penalty of up to $5,000 "for each violation" is sufficient to deter anyone thinking the freeze rules are without teeth.

The Internal Revenue Service has primary responsibility to enforce the wage/price controls, and it is pursuing this job very deliberately. The freeze has become a standard item of concern in tax audits, with early indications that perhaps one-third of a revenue agent's time normally devoted to a taxpayer's income tax records is instead being spent on payroll sheets, fee schedules or price lists, etc. Thus the likelihood of determining one's compliance with the controls may be the same as the odds of his tax return being audited. Since the odds are fairly substantial in the case of moderate and high income physicians, and even more substantial in the case of professional corporations, the freeze is far more than an academic matter.

As required by the rules, each practice should be sure it has available good records (payroll sheets, fee schedules, etc.) showing the items at their base period levels and at all times during the freeze. This should cause far less harassment for both the physician and the tax officials upon audit.

4. **Conclusion:** The wage/price controls are real, and for the foreseeable future they affect medical practices just as they concern giant corporations and labor unions. Practicing physicians and their advisors must consequently recognize the rules and be alert to any developments permitting sound decisions as to fee changes, wage increases, professional incorporation, and retirement planning.

Mr. Beck is president of Management Consulting for Professionals, Inc. of Bala Cynwyd.

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1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 196

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
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2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* **49**:855-64, 1970.

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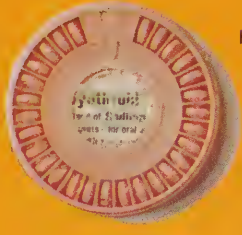

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American Druggist BLUEBOOK, March, 1971.

KNOWLEDGE OF THE '70's CHALLENGES CUSTOMS CONCERNING DESICCATED THYROID DRUGS.

In the past, desiccated thyroid produced from animal glands was considered "good, and cheap." We now know that improved products are available and the price difference has narrowed to the point of being inconsequential. (SYNTHROID, for instance, costs patients about a penny a day more than brands of desiccated thyroid.)

What does this additional $3.65 a year buy the patient? Quite a bit in terms of quality, reliability and service.

SWITCHING PATIENTS TO SYNTHROID IS EASY.

Switching present patients to SYNTHROID (or starting new ones) is a simple matter. SYNTHROID is available in the widest range of dosage strengths of any thyroid drug. Seven scored, color-coded tablet strengths are available plus a lyophilized injectable form for emergency or postoperative uses.

RESPONSE, RELIABILITY, SERVICE—COMPARISON OF FIVE PARAMETERS

PARAMETERS	DESICCATED THYROID U.S.P.	SYNTHROID® (sodium levothyroxine)
SOURCE OF HORMONE	Animal glands (swine, sheep, cows). Hormone content of glands and ratio of T_3-T_4 varies by type of animal, season in which gland is harvested, and diet of animal.[1,2,3,4,5]	Synthetically derived pure crystalline hormone. Because no animal protein is present, no objectionable odor occurs upon aging.
GENERAL ASSAY TECHNIQUE	"Its major disadvantage is inadequate standardization of hormonal content."[8]	Unlike desiccated thyroid U.S.P., thyroxine does not require biologic standardization to establish its potency.[2,6] Crystalline T_4 is used. Purity is verified by paper chromatography. Content of tablets is standardized by weight.
CLINICAL RESPONSE	"T_3 and T_4 ratio varies according to gland source. Fluctuations in response can occur. Potency can vary."[3]	"Sodium levothyroxine has been extensively used with satisfaction and is widely held to be superior to (desiccated) thyroid."[7] "There are well documented examples of patients who failed to respond satisfactorily to desiccated thyroid but subsequently responded to (sodium-1) thyroxine."[4]
PREDICTABILITY	Failure of thyroid U.S.P. treated patients to show clinical improvement and/or lack of correlation in clinical findings to thyroid function test results has been frequently discussed in the literature.[8,9,10,11,12,13,14,15,16] Regardless of which factor or factors accounts for this phenomenon the fact remains that discrepancies do occur.	Test results predictably elevated. ". . . oral potency of this material is attested to by a uniformly good clinical response corroborated by a prompt and sustained increase in the serum PBI levels."[16]

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See next pages for prescribing information.

APPROXIMATE DOSAGE EQUIVALENTS*

			Animal Gland		
CYTOMEL (Sodium liothyronine) Synthetic T_3	EUTHROID** (Liotrix) Synthetic T_3-T_4	THYROLAR*** (Liotrix) Synthetic T_3-T_4	Desiccated (Thyroid, USP) Cow, sheep or hog thyroid	PROLOID (thyroglobulin) Frozen hog thyroid	SYNTHROID (Sodium levothyroxine) Synthetic T_4
Unscored 5 mcg.	N.A.	N.A.	unscored ¼ gr.	¼ gr.	0.025 mg.
N.A.	½	½	unscored ½ gr.	½ gr.	0.05 mg.
25 mcg.	1	1	unscored 1 gr.	1 gr.	0.1 mg.
N.A.	N.A.	N.A.	N.A.	1½ gr.	0.15 mg.
50 mcg.	2	2	unscored 2 gr.	2 gr.	0.2 mg.
N.A.	3	3	unscored 3 gr.	3 gr.	0.3 mg.
N.A.	N.A.	N.A.	unscored 5 gr.	5 gr.	0.5 mg.
N.A.	N.A.	N.A.	N.A.	N.A.	Injectable 500 mcg.

N.A. = Not Available Commercially

*Equivalents shown are chemical, and do not take into consideration individual patient variables. Clinical effect is approximate and should be monitored when converting a patient to SYNTHROID. This is particularly important in patients previously on desiccated thyroid. In these patients, lower doses of SYNTHROID may produce the same metabolic effect.

**Euthroid (#1 tablet) contains 60 mcg. of T_4 and 15 mcg. of T_3.

***Thyrolar (#1 tablet) contains 50 mcg. of T_4 and 12.5 mcg. of T_3.

Synthroid®
(sodium levothyroxine)

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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THE FACTS ARE CLEAR AND HERE IS OUR OFFER.

Synthetic thyroid drugs are an improvement over animal gland products. Patients, even athyrotic ones, can be completely maintained on SYNTHROID (T_4) alone. Thyroid function tests are easy to interpret since they are *predictably* elevated when the patient adheres to SYNTHROID. Of all synthetic thyroid drugs, SYNTHROID is the most economical to the patient.

AA

OFFER:
Free TAB-MINDER medication dispensers to start or convert all your hypothyroid patients to SYNTHROID. Free information to physicians on role of thyroid function tests in a new booklet titled: "Guideposts to Thyroid Therapy." Ask us.

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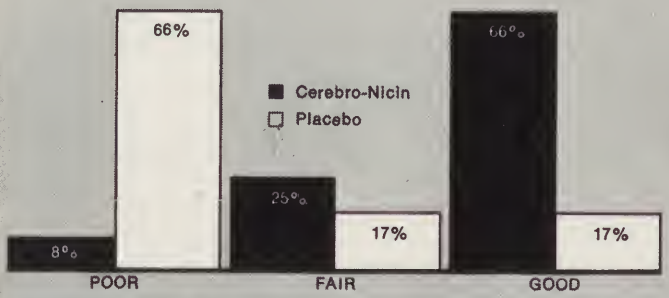
A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutemic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir 8 oz. bottles.

CONTRAINDICATIONS: There are no known contraindicetions to Pentylenetetrazole elthough caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondery reaction some will complain of nausea end other sensations of discomfort. This reaction is transient and is rerely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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The treatment of

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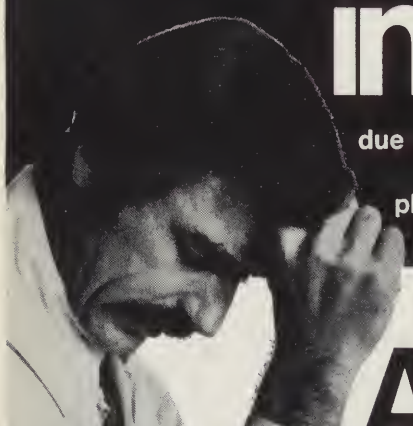
due to androgenic deficiency in the American male.
The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society



Android®

(thyroid-androgen) tablets

Double-Blind Study and Type of Patient:

100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android

Each yellow toblet contoins:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

REFER TO PDR

Android-HP

HIGH POTENCY

Each red tablet contoins:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contoins:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contoins:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canalliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

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ALSO AVAILABLE FOR THE TREATMENT OF

impotence

due to androgenic deficiency in the American male.

Android® 5 MUQETS *BUCCAL Tabs*

Methyltestosterone N.F.-5 mg.

Android® 10

Methyltestosterone N.F.-10 mg.

Android® 25

Methyltestosterone N.F. -25 mg.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4 en 3-one.

ACTIONS: Methyltestosterone is an oil soluble androgenic hormone.

INDICATIONS: In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency 3. Impotence due to androgenic deficiency. 4. Postpuberal cryptorchidism with evidence of hypogonadism.
Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued.

PRECAUTIONS: Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity.

CONTRAINDICATIONS: Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage.

WARNINGS: If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued

ADVERSE REACTIONS: Cholestatic Jaundice • Oligospermia and decreased ejaculatory volume. • Hypercalcemia particularly in patients with metastic breast carcinoma. This usually indicates progression of bone metastases. • Sodium and water retention. • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia.

DOSAGE AND ADMINISTRATION: Dosage must be stricly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following chart is suggested as an average daily dosage guide.

INDICATION	Average Daily Dosage Tablets
In the male:	
Eunuchoidism and eunuchism	10 to 40 mg.
Male climacteric symptoms and impotence due to androgen deficiency	10 to 40 mg.
Postpuberal cryptorchism	30 mg.

HOW SUPPLIED: 5, 10, 25 mg. in bottles of 60, 250.

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she has a plan
that works
LESSON
PLAN

She has a plan that works.

She has one plan for the class. And they really respond.

She has another plan just for herself. A medication plan for her hypertension. And she's also responding beautifully.

More than just another antihypertensive, Ser-Ap-Es can be a whole medication plan for living with hypertension.

Does it get good marks for comfort?

Excellent. Because Ser-Ap-Es controls blood pressure effectively, dosage of each component is lower than if prescribed alone, usually minimizing side effects. However, side effects may occur (see prescribing information).

Designed with the kidney in mind?

Hydralazine maintains or increases renal blood flow.

And the brain too?

Hydralazine also relaxes cerebral vascular tone. And reserpine has beneficial calming action.

Is strict dietary discipline necessary?

Hydrochlorothiazide eliminates excess salt and water. So dietary salt restrictions can be relaxed a bit.

Practical on a teacher's salary?

Ser-Ap-Es means single-prescription economy.

Will she do her "homework"?

More than likely. Ser-Ap-Es offers all the antihypertensive medication many patients need in a single tablet. It's easier. Encourages cooperation.

Ser-Ap-Es supplies many kinds of benefits…

Only Ser-Ap-Es adds Apresoline® (hydralazine) to rauwolfia-thiazide.

Please turn page for brief prescribing information.

C I B A

Ser-Ap-Es®

reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

a plan for living with hypertension

Ser-Ap-Es®

reserpine	0.1 mg
hydralazine hydrochloride	25 mg
hydrochlorothiazide	15 mg

INDICATIONS: All cases of hypertension except the mildest and the most severe.

CONTRAINDICATIONS

Reserpine: Known hypersensitivity; mental depression, especially with suicidal tendencies; active peptic ulcer; ulcerative colitis.

Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.

Hydrochlorothiazide: Anuria; progressive renal or hepatic disease; allergy to thiazides or other sulfonamide-derived drugs.

WARNINGS

Reserpine: Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia.

Electroshock therapy should not be given to patients receiving rauwolfia preparations, since severe and even fatal reactions have been reported. Discontinue for 2 weeks before giving electroshock therapy.

Hydralazine: Hydralazine, particularly if given for prolonged periods, may produce an arthritis-like syndrome, leading in rare instances to a clinical picture simulating acute systemic lupus erythematosus. Most of these reactions are reversible upon withdrawal of therapy. These side effects are not anticipated even with maximal recommended dosage of Ser-Ap-Es.

Hydrochlorothiazide: Small bowel stenosis, with or without ulceration, has been associated with use of enteric-coated thiazides with potassium, and with enteric-coated potassium alone. Coated potassium should be used only when dietary supplementation is not practical and discontinued if gastrointestinal symptoms arise.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is generally reversed by a uricosuric agent. Lowering of blood pressure may sometimes result in nitrogen retention, particularly in patients with impaired renal function. Dosage titration is necessary in such patients. Thiazides may decrease arterial responsiveness to norepinephrine and increase responsiveness to tubocurarine; if possible, withdraw therapy two weeks prior to surgery. Hypotensive episodes under anesthesia have been observed. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

The possibility of sensitivity reactions should be considered in patients with a history of allergy or bronchial asthma.

Use in Pregnancy

Reserpine: The safety of rauwolfia preparations for use in pregnancy or lactation has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.

Hydralazine: Although there has been no adverse experience with hydralazine in pregnancy, there have been no systematic animal reproduction studies to support the idea of safety in pregnancy. The drug should be used in pregnancy only when, in the judgment of the physician, it is deemed essential to the welfare of the patient.

Hydrochlorothiazide: Thiazides should be used with caution in pregnant or lactating patients since this drug crosses the placental barrier and appears in breast milk and may result in fetal hyperbilirubinemia, thrombocytopenia, or altered carbohydrate metabolism. It is therefore possible that the adverse reactions seen in the adult may occur in the newborn.

PRECAUTIONS

Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or other GI disorders. May precipitate biliary colic in patients with gallstones.

Discontinue at first sign of mental depression, keeping in mind possibility of suicide. Use with extreme caution in those with history of mental depression. Take special care with asthmatics and in hypertensives with renal insufficiency. Use cautiously with digitalis, quinidine, and guanethidine. Not recommended for aortic insufficiency.

Hydralazine: Use cautiously in suspected coronary artery disease, cerebral vascular accidents, and advanced renal damage. Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop. Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported rarely. If such abnormalities develop, discontinue therapy.

Periodic blood counts and liver function tests are advised during prolonged therapy.

Hydrochlorothiazide: Monitor indicated blood chemistry and fluid and electrolyte balance carefully in patients on thiazide therapy, especially when patient is vomiting, receiving parenteral fluids, steroids, or digitalis. Supplemental potassium and non-rigid salt intake will help prevent hyponatremia, hypochloremic alkalosis, and hypokalemia.

ADVERSE REACTIONS

Reserpine: Increased salivation, increased gastric secretions, nausea, vomiting, anorexia, aggravation of peptic ulcer or ulcerative colitis, increased intestinal motility, diarrhea, angina-like syndrome, ectopic cardiac rhythms particularly when used concurrently with digitalis, bradycardia, flushing, and mental depression, drowsiness, lassitude, nervousness, paradoxical anxiety, nightmares (which may be an early sign of mental depression), rarely atypical Parkinsonian syndrome, central nervous system sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy), pruritus, skin rash, dryness of mouth, dizziness, headache, syncope, epistaxis, purpura due to thrombocytopenia, asthma in susceptible persons, nasal congestion, weight gain, impotence or decreased libido, enhanced susceptibility to colds, dysuria, conjunctival injection, dyspnea, muscular aches.

Hydralazine: Common: Headache, palpitations, anorexia, nausea, vomiting, diarrhea, tachycardia, angina pectoris.

Less frequent: Nasal congestion; flushing; lacrimation; conjunctivitis; paresthesias; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity reaction including skin rash and vascular collapse; constipation; difficulty in micturition; arthralgia; dyspnea; paralytic ileus; lymphadenopathy; splenomegaly.

Hydrochlorothiazide: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, hyperglycemia, glycosuria, dizziness, vertigo, paresthesias, headache, xanthopsia, purpura, photosensitivity, rash, urticaria, necrotizing angiitis, leukopenia, thrombocytopenia, agranulocytosis, aplastic anemia, muscle spasm, weakness, restlessness. Orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE: One or 2 tablets t.i.d. To initiate therapy, 1 tablet t.i.d. is recommended. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

SUPPLIED: *Tablets* (salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 100 and 1000.

Consult complete literature before prescribing.

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Chlorpheniramine Maleate dries runny noses and eyes, quiets neezing, wheezing, soothes itching and reduces postnasal drip—ll with a particularly low index of side effects such as drowsiness.

Pseudoephedrine HCl: decongests throughout *entire* respiratory ract, opening nasal passages, dilating bronchioles, relaxing 'tight chest"—as effectively as ephedrine, but with much less CNS or cardiovascular stimulation.

COMPOSITION: Each tablet or 10 cc. (2 teaspoonsful) of liquid contains:

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INDICATIONS: For relief of upper respiratory and bronchial congestion associated with: the common cold, hay fever and allergies, sinusitis, influenza, and vasomotor and allergic rhinitis.

CONTRAINDICATIONS: Sensitivity to antihistamines or sympathomimetic agents. Severe hypertension or severe cardiac disease.

PRECAUTIONS: Use with caution in patients with hyperthyroidism. Patients susceptible to the soporific effects of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

CAUTION: Federal law prohibits dispensing without prescription.

SUPPLIED: Tablets: Bottles of 100; Liquid: Pints and gallons; Timesules: Bottles of 50, 250, and 1000.

DOSAGE AND ADMINISTRATION:	Tablets	Liquid	Timesule
Adults:	1 q. 3-4 h.	2 tsp. q. 3-4 h.	1 q. 12 h.
Children 6-12 years:		1 tsp. q. 3-4 h.	
40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

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Facts about Loridine® I.M. cephaloridine

Facts about activity

Loridine is indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed below.* It is active against the following organisms in vitro:

Beta-hemolytic and other streptococci (many strains of enterococci, e.g., *Streptococcus faecalis*, are relatively resistant)
Staphylococci, both coagulase-positive and coagulase-negative (some strains of staphylococci are resistant to cephaloridine)
Pneumococci
Gonococci
Hemophilus influenzae
Escherichia coli and other coliform bacteria
Klebsiella
Proteus mirabilis

Loridine also has demonstrated activity against *Treponema pallidum* in experimental syphilis studies in animals.

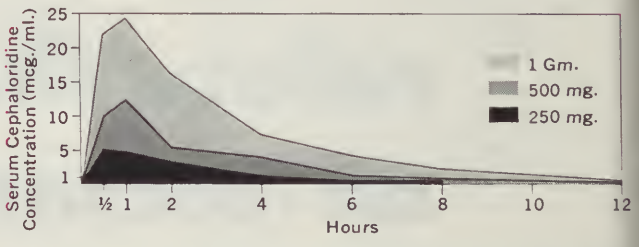
All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine. However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *H. influenzae*, *Pr. mirabilis*, *Esch. coli*, and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

*Loridine is indicated in the treatment of gonorrhea when penicillin is not considered the drug of choice.

Facts about dosage

In adults, most infections of moderate severity caused by susceptible organisms respond to Loridine in dosages ranging from 500 mg. to 1 Gm. every eight hours (1.5 to 3 Gm. daily). This use of lower dosages helps prevent drug accumulation. The more susceptible infections have been treated with 250 to 500 mg. every eight hours.



Mean Serum Cephaloridine Concentrations after I.M. Administration of Single Doses (250 mg. to 1 Gm.) to Normal Human Volunteers (Six to Eighteen Subjects per Group). (Modified from Currie, J. P.: Cephaloridine: Pharmacology and Toxicology, Postgrad. M. J., 43 [Supplement]: 22, 1967.)

Peak serum levels have been noted with Loridine within one-half to one hour following I.M. injection. The mean peak serum levels obtained in normal subjects one hour after a 500-mg. I.M. dose ranged from 12 to 22 mcg. per ml. in separate studies. Administration every six to eight hours permits adequate concentrations to be maintained. In order to avoid excessive serum levels (which could possibly result in damage to the kidney tubules), recommended dosages should not be exceeded. In adult patients without azotemia who have mildly reduced renal function manifested by slight to moderate, transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the *maximum* recommended dosage is 1 Gm. every twelve hours during the period of reduced function.

Facts about administration

The following guidelines for therapy with Loridine are recommended.

Before Administration of Loridine

1. Establish susceptibility of the pathogen.
2. Determine patient's renal status; Loridine is contraindicated in azotemia.

During Administration of Loridine

1. Maintain proper hydration.
2. Monitor renal status —urinalyses, urinary output, BUN, and/or serum creatinine.
3. Use cautiously with other potentially nephrotoxic drugs.
4. Because nephrotoxicity has been reported, limit dosage to 4 Gm. daily for adults (100 mg. per Kg. for children—not to exceed adult dosage). Usual adult dosage range: 1 to 3 Gm. daily.
5. In patients with impaired renal function *before* treatment, reduce daily dosage and keep them under close observation for changes in function. In nonazotemic patients with mildly reduced renal function manifested by slight to moderate, transient, or persistent reduction of urinary output or by creatinine clearances of 60 to 90 ml. per minute, the *maximum* recommended dosage (adults) is 1 Gm. every twelve hours during the period of reduced function.
6. In patients who develop impaired renal function or whose preexisting impairment becomes worse *during* treatment, discontinue therapy.

Since Loridine is relatively painless on I.M. injection, it is well accepted by patients.

There is clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins; therefore, Loridine should be used with great caution in patients with known penicillin allergy. Instances of patients who have had severe reactions to both drugs, including death from anaphylaxis, have been reported.

Loridine® I.M.
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Lilly

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(Please turn page for prescribing information.)

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Actions: All tested strains of group A streptococci, pneumococci, and penicillin-G-susceptible staphylococci are susceptible to Loridine® (cephaloridine, Lilly). However, some strains of penicillinase-producing staphylococci are resistant in vitro to concentrations of Loridine that can be achieved in the serum. The majority of strains of *Hemophilus influenzae, Proteus mirabilis, Escherichia coli,* and *Klebsiella* are also susceptible in vitro.

Pseudomonas organisms are resistant to Loridine, as are most indole-producing *Proteus* species and motile *Aerobacter* species.

Indications: Indicated in the treatment of serious infections of the respiratory tract, genito-urinary tract, bones and joints, bloodstream, soft tissue, and skin due to susceptible strains of the organisms listed above; in early syphilis when penicillin may be contraindicated (see Warnings in regard to cross-sensitivity with penicillin); and in gonorrhea when penicillin is not considered the drug of choice.

Loridine should not be used until culture and sensitivity tests show that the organism is susceptible to its action and until renal status of the patient has been determined. For this reason, the drug should not normally be used to initiate therapy. Culture and sensitivity tests are not feasible for patients with syphilis; results of such tests are usually not available before antibiotic treatment of gonorrhea is given.

Contraindications: Azotemia. Hypersensitivity to cephaloridine or cephalothin.

In its present form, Loridine is poorly absorbed from the gastro-intestinal tract and should be given only by injection. Because of slower excretion in patients with impaired renal function, their total daily dosage should be proportionately less than that for persons with normal renal function.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN C DERIVATIVES SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. INSTANCES OF PATIENTS WHO HAVE HAD SEVERE REACTIONS TO BOTH DRUGS, INCLUDING DEATH FROM ANAPHYLAXIS, HAVE BEEN REPORTED.

Because of nephrotoxicity (e.g., tubular necrosis) of cephaloridine in dosages above 4 Gm. daily (see Adverse Reactions), recommended doses should not be exceeded. Patients with known or suspected impairment of renal function should be under close clinical observation for changes in renal function or be hospitalized. If impaired renal function develops during therapy, cephaloridine should be discontinued. Cephaloridine should not be used in patients with azotemia. When renal impairment is present, use the drug with caution and reduce the dose. Casts in the urine, proteinuria, falling urinary output, or a rising BUN or serum creatinine may indicate impairment of renal function. Give cephaloridine cautiously when it is used with other antibiotics having nephrotoxic potential.

Precautions: Protect ampoules from light. Extemporaneous mixtures with other antibiotics are not recommended.

In infections due to beta-hemolytic streptococci, continue antibiotic therapy for at least ten days to prevent the possible occurrence of rheumatic fever or glomerulonephritis in susceptible patients. In gonorrhea, patients with suspected concomitant syphilis should have dark-field examinations of all suspect lesions before treatment and monthly serologic tests for a minimum of three months. Indicated surgical procedures should be performed.

Superinfections may develop with organisms not in the spectrum of Loridine, particularly *Pseudomonas*. These can be recognized by clinical observation and by means of appropriate cultures. If they occur, take proper therapeutic measures.

Safety for use during pregnancy has not been established.

Since safety in premature infants and infants under one month of age has not been established, cephaloridine in these patients is not recommended.

A few patients have developed positive direct Coombs tests during cephaloridine treatment. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received Loridine before parturition, a positive Coombs test may be due to the drug.

A false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinitest® tablets but not with Tes-Tape® (urine sugar analysis paper, Lilly).

Adverse Reactions: Urticaria, skin rash (maculopapular or erythematous), and itching without discernible skin changes have been observed in about 3 percent of patients. Some of these were known to be allergic to penicillin. Others with known allergy to penicillin have been given Loridine without difficulty. Approximately 1 percent of patients treated with Loridine have had a rise in eosinophil count. Eosinophilia reached 10 percent in about half of these. A few instances of drug fever have been reported.

A few cases of leukopenia have been reported. Elevations of transaminase were observed in a small percentage of patients. In most instances, the elevations were in a single determination when other parameters of liver function were normal, and only rarely was a level of 100 units reached. In a few cases, similar elevations of alkaline phosphatase were found. The significance of these observations is uncertain.

In controlled studies on forty-three healthy persons given 2 Gm. cephaloridine intramuscularly twice daily for four weeks, no significant changes were observed in BUN, alkaline phosphatase, SGOT, reticulocyte count, or monocyte count in the blood. No disturbances in hemoglobin or red-blood-cell count were ascribable to administration of Loridine. However, all of five nonazotemic patients with chronic bacteriuria who had careful renal function evaluation before and after a ten-day course of cephaloridine in dosages of 2 Gm. per day developed impairment in free water clearance.

Severe, acute renal failure, in some cases terminating in death, has occurred in a small number of patients. The possibility of this complication seems to be greater in seriously ill patients given more than recommended doses. Acute tubular necrosis has been found in affected patients coming to autopsy. Rare cases of nausea and vomiting have occurred. Pain in association with intramuscular injection was noted in less than 3 percent of patients. In only one patient in a series of 623 was the route changed on this account. Phlebitis at the site of intravenous injection has been rare.

Administration and Dosage: *Important*—Before administering Loridine, see package insert for details on dilution.

Intramuscular Injection—Loridine is usually injected into a large muscle mass.

The usual adult dosage for many infections of moderate severity is 500 mg. to 1 Gm. three times a day at equally spaced intervals. Milder and more susceptible infections have been treated with 250 to 500 mg. given two or three times a day. More severe infections may be treated with 500 mg. to 1 Gm. four times a day. A single 2-Gm. dose is recommended for the treatment of acute gonorrhea. Early syphilis may be treated with 500 mg. to 1 Gm. daily for ten to fourteen days.

Although some clinical experience with high doses for life-threatening conditions has been reported, it has been shown that excessive dosages (above 4 Gm. daily) may cause serious nephrotoxic reactions. For this reason, Keflin® (sodium cephalothin, Lilly) may be preferred when doses larger than 4 Gm. daily are considered for life-threatening situations. If more than 2 Gm. of cephaloridine is injected daily, the patient should be under close clinical observation for changes in renal function or be hospitalized. In addition, reduced dosage should be employed in patients with known or suspected renal impairment.

In children, a daily total of 30 to 50 mg. per Kg. (15 to 25 mg. per pound) of body weight, given in divided doses, has been found effective for mild to moderately severe infections. A daily total of 100 mg. per Kg. (50 mg. per pound) of body weight (not to exceed recommended adult doses) may be needed for very severe infections.

Intravenous Injection—In the presence of extremely serious infections (such as bacteremia) or when any infection seems overwhelming, intravenous administration may be indicated.

Total daily dosages are the same as with intramuscular injection. For very susceptible organisms, 500 mg. to 1.5 Gm. per day may suffice; for less susceptible organisms and for serious infections, 2 to 4 Gm. per day may be needed.

How Supplied: Ampoules Loridine® (cephaloridine, Lilly), 500 mg., 5-ml. size, rubber-stoppered; 1 Gm., 10-ml. size, rubber-stoppered. [082169]

Additional information available to the profession on request.

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NOT TIMED **LIPO-NICIN®/100mg.** **Each blue tablet contains:** Nicotinic Acid .....100 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCl (B-1) .. 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCl (B-6).. 10 mg. **DOSE:** 1 to 5 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000.	NOT TIMED **LIPO-NICIN®/250mg.** **Each yellow tablet contains:** Nicotinic Acid .....250 mg. Niacinamide ..... 75 mg. Ascorbic Acid .....150 mg. Thiamine HCl (B-1) .. 25 mg. Riboflavin (B-2) ..... 2 mg. Pyridoxine HCl (B-6).. 10 mg. **DOSE:** 1 to 3 tablets daily. **AVAILABLE:** Bottles of 100, 500, 1000.	TIMED RELEASE 6 to 8 HOURS **LIPO-NICIN®/300mg.** **Each capsule contains:** Nicotinic Acid .....300 mg. Vitamin C (Ascorbic Acid).150 mg. Vita. B1 (Thiamine HCl).. 25 mg. Vitamin B2 (Riboflavin) .. 2 mg. Pyridoxine HCl (B-6) .... 10 mg. **DOSE:** 1 to 2 capsules daily. **AVAILABLE:** Bottle of 100, 1000. *In a special base so prepared that the active ingredients are released over a period of 6 to 8 hours.*

SIDE EFFECTS: Flushing with heat and itching, in some cases followed by sweating, nausea and abdominal cramps. This reaction is usually transient. Nausea caused by high acidity can be relieved by non-absorbable antacid. **REFERENCES: 1.** *Parsons, W.B., Jr. — Interview Med. Trib. Nov. 28-29, 1964.* **2.** *Cohen, D., JAMA, Aug. 6, 1960, Vol. 173, No. 14, P. 1563.*

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a tablet for the day keeps congestion away,
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The round-the-clock oral decongestant

Clinical Considerations: Indications: DRIXORAL is indicated for round-the-clock relief of symptoms of upper respiratory mucosal congestion in seasonal and perennial nasal allergies, acute rhinitis and rhinosinusitis, and eustachian tube blockage. **Contraindications:** DRIXORAL should not be given to children under 12 years of age. DRIXORAL should not be administered to pregnant women or nursing mothers until the safety of this preparation for use during gestation and lactation is established. The preparation is contraindicated also in patients with severe hypertension and coronary artery disease. **Warnings:** As in the case of other preparations containing central nervous system acting drugs, patients receiving DRIXORAL should be cautioned about possible additive effects with alcohol and other central nervous system depressants (hypnotics, sedatives, tranquilizers). For the same reason they should be cautioned against hazardous occupations requiring complete mental alertness such as operating machinery or driving a motor vehicle. **Precautions:** Isoephedrine-containing preparations should be used with caution in the presence of: hypertension; coronary artery disease; any other cardiovascular disease; glaucoma; prostatic hypertrophy; hyperthyroidism; diabetes. **Adverse Reactions:** The physician should be alert to the possibility of all possible adverse reactions which have been observed with sympathomimetic and antihistaminic drugs. These include: drowsiness; confusion; restlessness; nausea; vomiting; drug rash; vertigo; palpitation; anorexia; dizziness; dysuria due to vesicle sphincter spasm; headache; insomnia; anxiety; tension; weakness; tachycardia; angina; sweating; blood pressure elevation; mydriasis; gastric distress; abdominal cramps; central nervous system stimulation; circulatory collapse. **For more complete details, consult package insert or Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 07083.**

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PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

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m.d.'s in the news

A. Curtis True, M.D. has been appointed director of medical services at Merck, Sharp and Dohme.

John H. Dossett, M.D., Mobile, Ala., has been named assistant professor of pediatrics at Milton S. Hershey Medical Center of Pennsylvania State University. Most recently, Dr. Dossett was staff pediatrician at Malcolm Grow U.S.A.F. Medical Center, Andrews Air Force Base, in Washington, D.C.

Luther L. Terry, M.D., has resigned as vice-president for medical affairs of the University of Pennsylvania, a post he had held since 1965, in order to devote his full time to teaching in the Department of Community Medicine. **Robert D. Dripps, M.D.,** professor and chairman of anesthesiology, will serve as acting vice-president until a permanent successor can be found.

Milton J. Freiwald, M.D., Philadelphia, has written a paper entitled "Chalazion? Suspect Cancer." It has received wide recognition since its publication in the February 1971 issue of *Medical Times*.

Marvin Clark, M.D., and his wife, **Sandra Clark, M.D.,** Brookville, have volunteered to give two months of medical service to the Mettu Hospital in Ethiopia, a 65-bed government hospital serving 600,000 people.

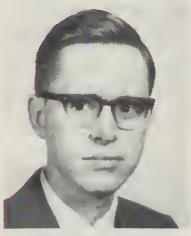
Robert B. Greer, III, M.D., has accepted a position as associate professor of surgery and chief of the division of orthopedic surgery at the Milton S. Hershey Medical Center of Pennsylvania State University. His most recent position was as a member of the orthopedic surgery faculty at the University of Pittsburgh.

Bruce H. Carney, M.D., Norristown, who has completed fifteen years as editor of the *Bulletin* of the Montgomery County Medical Society, has been appointed director of the Department of Obstetrics and Gynecology at Montgomery Hospital in Norristown.

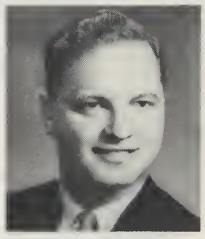
Harriet C. Jones, M.D., Philadelphia, has been appointed director of Temple University's West Nicetown-Tioga Family Neighborhood Health Center. She was formerly chief of the school health division in the Bureau of Maternal and Child Health in Washington, D.C.

Paul Shallenberger, M.D., Waverly, president of the Bradford County Medical Society, presented a complete copy of the minutes of the Bradford County Medical Society from 1849-1961 to the State Society. The original volumes are in the medical library at Robert Packer Hospital, Sayre.

Robert J. White, M.D. has been appointed associate in the department of community medicine at Geisinger Medical Center, Danville.



DR. WHITE



DR. MOSS

N. Henry Moss, M.D., associate clinical professor of surgery and attending surgeon at Temple University Health Sciences Center and Albert Einstein Medical Center, is the new president of the American Medical Writers Association.

Several appointments have been announced by the University of Pittsburgh School of Medicine. **Peter J. Jannetta, M.D.** was named professor of neurological surgery and director of the division of neurological surgery. Prior to this appointment, he was professor of surgery at the Louisiana State University Medical School. **Robert R. Carpenter, M.D.,** was promoted to associate professor of medicine and associate professor of community medicine. He is director of the Western Pennsylvania Regional Medical Program.

John J. Peters, Jr., M.D., formerly assistant director of the VA Hospital at Richmond, Va., has been named director of the Altoona VA Hospital.

Alexander M. Minno, M.D., was appointed to the Professional Advisory Committee of Harmarville Rehabilitation Center, Pittsburgh. He has served the center as a consultant in rheumatolgy.

Temple University School of Medicine has announced that an alumnus and a faculty member have been elected to Alpha Omega Alpha honorary society. **Angelo M. DiGeorge,** M.D., Philadelphia, is the alumnus

AT THE FIRST annual meeting of the Susquehanna Valley Regional Medical Program are, left to right, George P. Rosemond, M.D., PMS president; Ellsworth R. Browneller, M.D., Danville, retiring chairman of the SVRMP Regional Advisory Group; George C. Williams, Esq., a Wellsboro attorney and RAG vice-chairman, who became chairman; and Harold Magulies, M.D., director of the RMP service of the Department of Health, Education, and Welfare.

member. **R. Robert Tyson, M.D.,** Philadelphia, the faculty member, is a member of the Council on Medical Service and chairman of the Committee on Constitution and By-Laws of PMS.

DR. BUCHERT

Walter I. Buchert, M.D., medical director of the Geisinger Medical Center, has been installed as president of the American Association of Medical Clinics (AAMC). He is one of the originators of AAMC's Trusteeship for Health Program, a new group practice concept which is being implemented as a pilot project at the Geisinger Medical Center.

William A. Sodeman, Sr., M.D., dean and vice-president of Jefferson Medical College, received the Distinguished Alumni Award of the University of Michigan for 1971 for his work in medical education. Dr. Sodeman is president-elect of the American College of Physicians.

Commander George E. Ehrlich, M.D., Philadelphia, was unanimously chosen as recipient of the Philip S. Hench Award of the Association of Military Surgeons of the U.S. for his role as a teacher in the field of rheumatology.

Harry A. Smith, M.D., Wilkes-Barre, was chosen Pennsylvania Physician of the Year by the Governor's Committee on Employment of the Handicapped. Dr. Smith has been an orthopedic surgeon in Wyoming Valley for more than forty-five years and was one of the founders of the Wyoming Valley Crippled Children's Association.

E. O. Moehlmann, M.D., Richmond, was honored with a parade and dinner by the townspeople in appreciation of thirty-eight years of service, during which time he has been the only physician in town.

George E. Way, M.D., Hellertown, has been appointed chief of general practice at St. Luke's Hospital, Bethlehem. He succeeded **Paul Budura, M.D.,** who has resigned from the post but will remain on the staff.

Stephen E. Matsko, M.D., Allentown, was named a member of the Coaldale Hospital surgical staff. He is a fellow of the American College of Surgery.

George E. Gittens, M.D., Mount Airy, was promoted from assistant director to director of the Temple University School of Medicine unit at Philadelphia State Hospital (Byberry). **Frank W. Johnson, M.D.,** was promoted to clinical director of Byberry.

DR. JOHNSON

DR. WALDMAN

Sydney Waldman, M.D., has been appointed a staff physician in pediatrics to the Daroff Division, Albert Einstein Medical Center, which is being reopened after a four-year lapse. He has also joined the Philadelphia Medical Group, a private practice group based at the hospital to serve the South Philadelphia area.

S.P. Barua, M.D., Greensburg, has been appointed associate director of orthopedic surgery at Monsour Hospital and Clinic, Jeannette.

Albert H. Bucher, M.D., and **Hugh R. Gilmore, Jr., M.D.,** both of Hummelstown, received plaques from PMS honoring fifty years of service. Dr. Bucher is an orthopedic consultant at Polyclinic and Holy Spirit Hospitals, Harrisburg. Dr. Gilmore is chief of the cancer control section of the Pennsylvania Department of Health.

Charles A. Laubach, Jr., M.D., Enterprise, has been awarded the American Heart Association Distinguished Service Medallion. He is the immediate past president of the Pennsylvania Division.

James R.V. Heller, M.D., Bethlehem, received a fifty-year award for service in the borough of Coplay.

C. Reed Gennaria, M.D., Bloomsburg, has retired after forty-eight years of medical service, forty of which were to the community of Shamokin.

John F. Wilson, M.D., associate professor of dermatology at Jefferson Medical College has been elected president of the Pennsylvania Academy of Dermatology.

The Pennsylvania Heart Association has announced new officers. **Harry F. Zinsser, M.D.,** Gladwyne, is president, **Lawrence F. Blackburn, M.D.,** Greensburg, president-elect; and **Albert J. Cross, M.D.,** Scranton, vice-president. **Fred D. Fister,** M.D., Allentown, was reelected chairman of the board of directors of the Heart Association of Mideastern Pennsylvania.

L. Clair Burket, M.D., Altoona, was elected president of the Easter Seal Society for Crippled Children and Adults of Blair County.

William A. Yates, M.D., Johnstown, will head the professional healing arts division of the Greater Johnstown Community Chest — Red Cross Fund Drive.

A CENTENARIAN AWARD from the Pennsylvania Medical Society is presented to Otto Glace, Selinsgrove, on the occasion of his one hundredth birthday by Francis P. Sayers, M.D., president-elect of the Northumberland County Medical Society. Mrs. Sayers watches the presentation to the retired lumberman and district caretaker for the Department of Highways.

book review

Management of Juvenile Diabetes Mellitus. by Howard S. Traisman, 2d ed. 223 pp. illus. St. Louis: C.V. Mosby Co., 1971. $19.75

As stated in the preface, "the purpose of this book is to provide a concise, practical method of management of juvenile diabetes mellitus." The material is arranged in an orderly manner beginning with the etiology, pathogenisis, and diagnosis of juvenile diabetes mellitus. In this way, a basic approach is furnished for those whose knowledge of the disease may be superficial because of infrequent contact.

The chapters on the diagnosis of juvenile diabetes mellitus, instruction of patients and parents, psychologic aspects of juvenile diabetes mellitus and hypoglycemia are particularly worthwhile. Many of the procedures and instructional materials utilized at the Children's Memorial Hospital of Chicago are presented in detail.

The author is a believer in the "strict control" school of diabetes, which is amply demonstrated in the chapter on dietary treatment. On reading the chapter on the psychologic aspects of diabetes in childhood, there appears to be some inconsistency in the claim that rigid adherence to a strict diabetic regimen leads to better emotional adjustment while advocating flexibility for some teenagers. It is debatable whether the near perfectionistic personality as the end result of rigid diabetic control is as desirable as the authors claim.

Short bibliographies are included at the end of each chapter for further reading. The book embraces several appendices, useful for the student and graduate nurse engaged in the care of juvenile diabetics. It is a well indexed volume.

The author and his six contributors have accomplished their goal of providing a comprehensive monograph intended for pediatricians, family physicians and medical students.

David A. Smith, M.D.
Medical Editor

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Time to change the law

The recent recommendation by the Public Health Service Advisory Committee on Immunization Practices to discontinue the routine Smallpox vaccinations in this country has been brought to the attention of Pennsylvania physicians by the Secretary of Health, Dr. J. Finton Speller.

The formal recommendation contained in a booklet "Vaccinations Against Small Pox In The U.S." prepared by the Public Service, reads as follows:

> The Committee has reviewed the success achieved so far by the World Health Organization-sponsored smallpox eradication effort and fully expects that it will continue. It now believes that the risk of smallpox in the United States is so small that the practice of routine smallpox vaccination is no longer indicated in this country.
>
> The Committee believes that public health efforts should be devoted to assuring adequate immunization of all personnel involved in health service and of *all* travelers to and from continents where smallpox has not been eradicated.
>
> Because of the rapidly declining incidence of smallpox in the world and the vastly reduced risk of its being imported into the United States, health officials in the United States should consider the discontinuation of compulsory measures as they relate to routine smallpox vaccination.
>
> Finally, physicians and public health agencies should intensify efforts to assure that all adverse vaccine reactions are reported and that the following contraindications to smallpox vaccination are scrupulously observed:
>
> (1) Eczema and other forms of chronic dermatitis in the person to be vaccinated or in a household contact
> (2) Pregnancy
> (3) Altered immune states from disease or therapy.

Much data has been accumulated to support this recommendation of selected vaccinations. To implement this recommendation in Pennsylvania, it will be necessary to repeal that section of the Pennsylvania School Code that requires compulsory Smallpox vaccination to school children.

Pennsylvania physicians must assume an active role in eliminating the unnecessary risks of Smallpox vaccinations to children. Such positive action will once again demonstrate to the public the medical profession's continuing ability to respond to the changing medical needs of society.

DAS

'Let George say it'

Responsibility

As Walter Cronkite put it, the Attica prison riots and their tragic outcome have polarized public opinion to a marked degree. The cations and the anions have reported to their respective poles closely and faithfully. One group is ready to re-open the Bastille, complete with rack and thumb-screw; the other wants to turn each jail into a country club.

Your correspondent, with no answers to the many questions involved, is inspired to pity for all concerned. By his own light each did the best he could in an impossible situation. After first assuming that Commissioner Oswald had acted with harsh haste, I have concluded that he made an executive type decision. Damned on either side, he took a calculated risk.

If the commissioner, at the first news, had taken a large sheet of paper and written at the top the best possible outcome and at the bottom the worst that could happen, it might have given him pause. His most hoped for eventuality would have been a rapid and amicable settlement with release of all the hostages, unharmed. At the bottom of the page would have been a grizzly picture of dead and wounded hostages and convicts. Certainly the outcome came close to the worst.

I am sure this blood will be on Mr. Oswald's conscience for a long time, but he was accountable and he took what appeared to him to be appropriate action. No one can prove for certain that other measures would have been more successful. Many worse results are conceivable.

Governor Rockefeller does not come off so easily, in my opinion. Although Oswald was the delegated official responsible for this situation, Rockefeller, in the final analysis, has responsibility for the whole state. Attica was a disaster area. The death toll was comparable to major floods and hurricanes.

Nobody knows what effect the Governor's presence would have had at Attica. It is hard to see that it would have in any way worsened the situation. It would have given the involved people on both sides the assurance the state was taking the matter seriously. It would have given Oswald the certainty that the Governor understood what the commissioner's plan was. It would have given the Governor a clear picture of what was really going on in the battlefield, the knowledge that the action proposed was appropriate to the situation. Oswald is like the doctor who went to the bedside of his patient, could not get a consultant to come, made a decision of his own, and had a result which was not entirely successful. He used his best judgment. Rockefeller is the surgeon who from bed approved the intern's plan of treatment and found himself next day less than happy about the outcome. He could have done more.

GAR

omment on CV Brief

We are writing to comment on the Cardiovascular Brief Anesthesia in patients with cardiovascular disease, Part I" October, 1971), in which Dr. James M. Fenstermacher tes that the neuromuscular blocking agents succylcholine and d-tubocurarine have no cardiac effects. In ct, cardiac arrythmias following administration of succylcholine have been the subject of many reports.[1-5].

Bradycardia after a repeated dose of succinylcholine was und in 88% of patients by Lupprian and Churchill-vidson,[3] and 80% of patients by Mathias and Evans-losser.[6] Schoenstadt and Witcher[7] considered choline, oduced by the hydrolysis of succinylcholine, to cause senization of the patient to subsequent doses of succylcholine. After sensitization, the arrythmias are oduced by the unaltered molecules of succinylcholine. iopental appears to eliminate or reduce the incidence of rythmias.

Dowdy and Fabian[8] investigated the incidence of cardiac rythmias induced by succinylcholine in digitalized patnts and laboratory animals. Their results suggested that ravenous succinylcholine can produce serious ventricular rythmias in fully digitalized patients and dogs, and that e arrythmias can be abolished by d-tubocurarine. Dowdy, ggar, and Fabian in 1965 and Dowdy[10] in 1970 studied ects of neuromuscular blocking agents on isolated gitalized mammalian hearts, and concluded that succylcholine increased the effect of digitalis on the conucting system of the heart and made the ventricles more irable. Ventricular arrythmias caused by digitalis overdose d by the action of succinylcholine on a digitalized heart uld be reversed by d-tubocurarine.

In view of the protective effect of d-tubocurarine scribed above, it is interesting that Dowdy and her olleauges[10] have recently shown that antibacterial presvatives in the commercial preparation of d-tubocuraine ailable in the United States have a marked negative inotpic effect on the heart and that d-tubocurarine itself has alight positive inotropic effect. Clarke and Lyons[11] have inted out that "Tubarine", the preparation of d-tbocurarine available in Great Britain, contains no antbacterial or antioxidant preservatives, yet has been shown tcause highly significant decreases in blood pressure in th healthy and poor-risk adult patients. This hypotension isconsidered due to histamine release, or, more likely, nglionic blockade.

It should also be pointed out that gallamine, a frequently ud non-depolarizing muscle relaxant, has been associated vh an increase in heart rate, an effect due to both a vgolytic effect similar to atropine, and to a positive inotpic effect which can be blocked by propranolol.[12]

In summary, there are several highly significant cardiac ects of the commonly used neuromuscular blocking ents. These effects are especially important in patients with cardiovascular disease and should be recognized by anesthesiologists when they occur.

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Medical school—new approach

Of those students who are committed to the pre-medical preparation of three or four years of college, an alarmingly high percentage never reaches candidacy for medical school. Conversations with many of my student acquaintances lead me to conclude that there is great variation from college to college in the severity of grading student performance, particularly in the difficult sciences of physics and chemistry. Indeed, in some colleges, professors in these subjects seem to "wash out" a significant proportion of students.

It is common knowledge that for admission to medical school the student must perform with uncommon excellence in these sciences. We would not presume to know what facilities make a good physician, but it must be admitted that we really need those who can and will care for the sick in the communities across the land.

Perhaps we need to generate a group of medical school candidates who are humanities oriented, albeit moderately proficient in the pure sciences. Obviously such candidates are not likely to present themselves to an admissions committee with 3.5 averages in physics and chemistry, but by the same token they may demonstrate uncommon capabilities in philosophy, social sciences, and languages. The present system grinds the pre-medical student's powder too finely and too homogeneously, largely because admissions

policies have imposed this need upon conscientious colleges which take pride in getting their students into medical schools.

In the past decade 100,000 candidates, all having spent much time, effort, and money, have been lost because they were refused admission to medical school. Members of admissions committees have told me that the differences between those admitted and rejected are often so slight that the final decisions are painful. Of course, everyone realizes (and has realized since the early 50's) that more medical students are needed. This means more medical schools and larger classes.

The first thought, of course, is to build more medical schools. The great cost simply to assemble bricks, mortar and physical plant is something like $50 million, if one excludes erecting a hospital for teaching purposes. Still, a militarily oriented economy can spend this amount to construct one missile-carrying submarine. Dare we hope that our legislators could approach the building of medical schools with the same fervor they direct to instruments of defense and aggression?

At any rate, the time factor is of such great magnitude that few pragmatists can see any immediate solution to the problem by building more schools. Yet the crisis in health care is immediate, and at the very core is the gross numerical shortage of physicians.

By integrating existing facilities, it would be possible to multiply our medical educational capabilities within a two-year period, and at a fraction of the cost involved in constructing new schools. By facilities for such education we mean buildings, faculty, and hospital teaching beds— the three components difficult to grow anew.

There are many excellent colleges which could develop adequate courses in the medical sciences, especially with reasonable subsidies. It ought to be possible to move away from the concept that a medical school must be a place with large brick buildings. Why not think of the school as an administrative center with the ability to subcontract its courses among a number of teaching facilities? This satelliting could take place at all levels of medical education, and it would move the students in sections from school to school according to prior planning and scheduling.

Another area seemingly ripe for use is the clinical area. There are a number of board certified generalists, internists, surgeons, and pediatricians delivering care at the community level across the United States. Many of these are alert students, capable teachers, experienced in the care of the ill. It might be possible to organize these valuable people to provide highly acceptable senior preceptorships on an almost one to one basis. Not the least attractive element is that of providing expansion of capable faculty without expansion of cost.

Related to all of the foregoing is the very serious matter of producing physicians to care for those who are ill. Reviewing the new physician listings in our own county, I am increasingly alarmed at the paucity of physicians entering a community for the purpose of seeing and caring for sick people.

It may be that there are prejudices unconsciously fostered while the young student is still in medical school. Operating costs for medical education are presently largely met by federal and state monies — obtained by grant seekers who in turn direct and conduct medical research. In the natural course of events the complexion of faculty has been changed from community oriented clinicians to school oriented academicians and researchers. In no way do I degrade the need for the latter, but there is regret because of the disappearance of the former.

There is a great satisfaction and uncommon privilege attached to the delivery of quality medical care in a well-operated community hospital and a reasonably well-organized office practice. Few medical students really have the opportunity to work with successful physicians under both circumstances. If they did more students might find the circumstances attractive and rewarding — sufficiently so that more would enter this kind of career. These suggested changes are capable of increasing medical school enrollments.

There are under-utilized potentials in the pure sciences and in clinical medicine — potentials which could be organized to expand the teaching capabilities of medical schools. The cost of such maneuvers would be a fraction of that required to build medical schools to provide the same expansion. The career of delivering medical care at the community level is without peer in the opportunity for altruism combined with a life of study. It is at times arduous and difficult but never dull.

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Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

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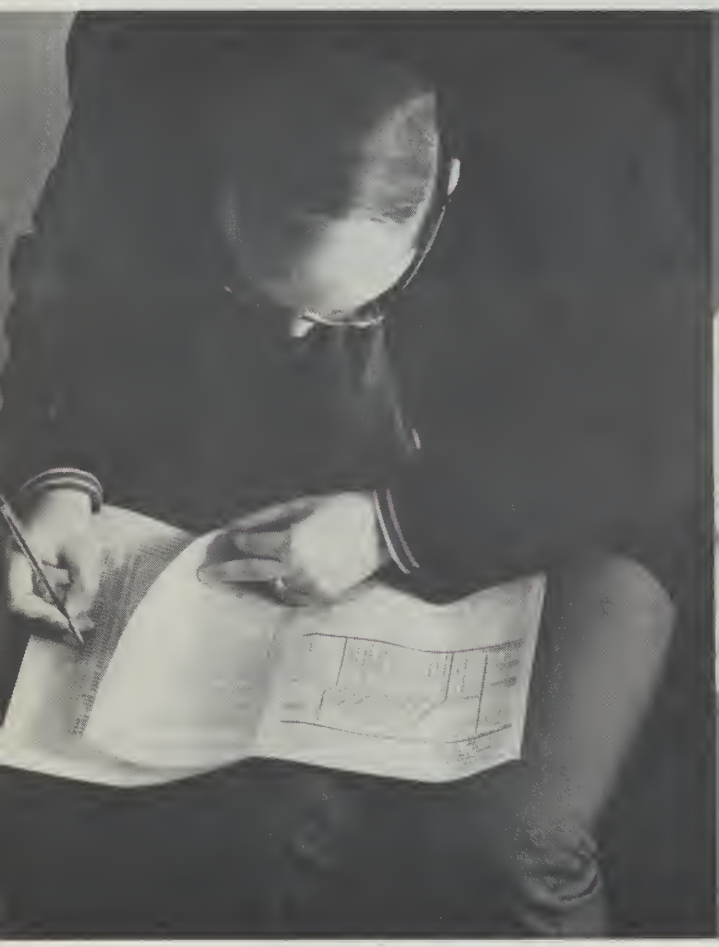

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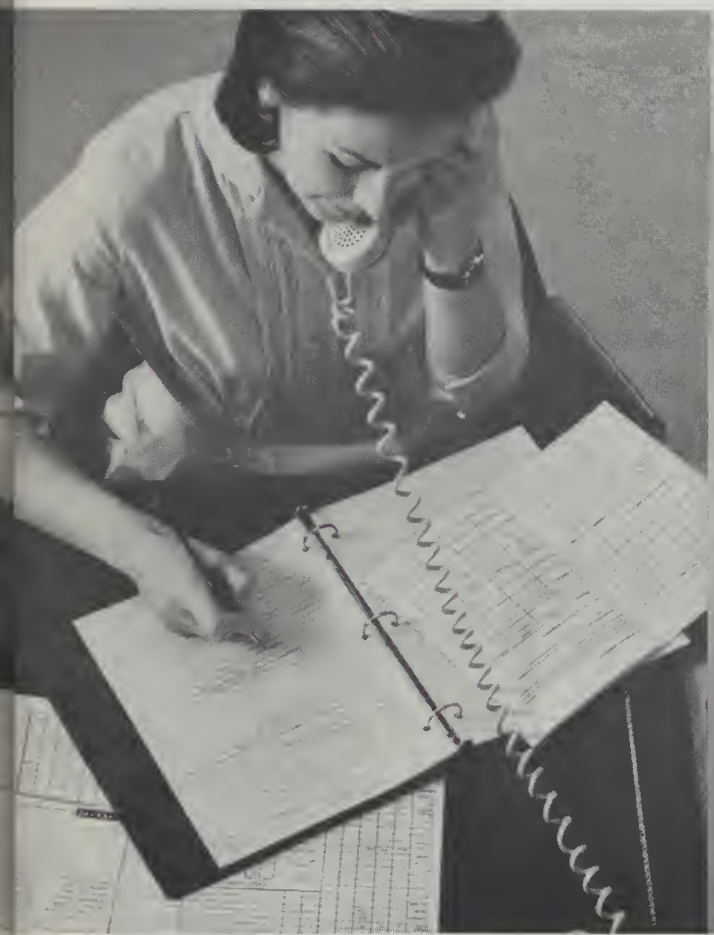

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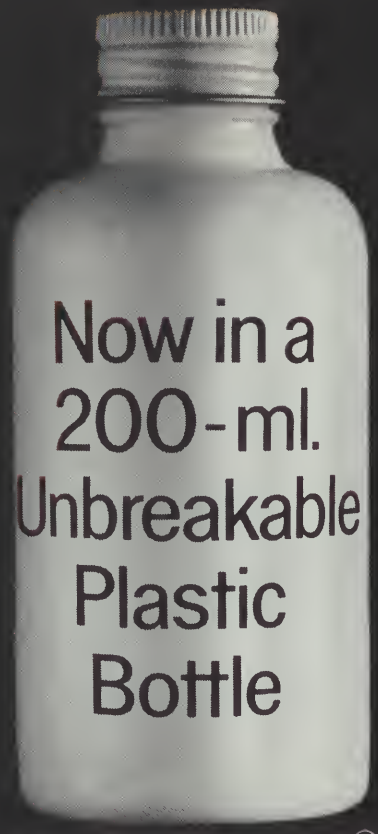

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Carotid Cavernous Sinus Fistulas

WILLIAM SILVERNAIL, JR., M.D.
Harrisburg

'A case report of the carotid-cavernous fistula is described. A brief summary of the clinical and radiographic findings and a review of the neurosurgical literature regarding the various surgical approaches is presented. This paper represents an endorsement of the muscle embolization technique utilizing the Jaeger maneuver.'

Surgical efforts to produce a complete cure in cases of carotid cavernous sinus fistula or pulsating exophthalmus (its leading symptom) will be acceptable only when they fully occlude and plug the fistula, avoid cerebral emboli, and result in a negligible mortality rate. Many excellent studies have been made and introduced through the years attempting to deal with this problem, starting with Travers' case report in 1811 of treatment by ligating the common carotid artery.[1] Numerous procedures have been designed and developed based on the contributions of dedicated surgeons whose successes, failures, and preferences have been fully reported and reviewed in the literature.[2,3,4,5,6]

Figure I

Case Report

L.S., a 61-year-old white female, was admitted to the hospital on October 24, 1967, for study and treatment of a cranial bruit of spontaneous onset in July 1967. The bruit was synchronous with her heartbeat and she was unable to lo-

Figure II

calize it. It was loudest lying down and had been present continuously for three months prior to admission. Just prior to onset of the bruit in 1967, she experienced fairly severe right retro and periorbital headache.

Past medical history revealed that she took a daily medication for hypertension and had been treated for carcinoma in-situ of the cervix with radium.

Physical examination revealed a blood pressure of 160/76. She had hyperemia and venous dilatation of the conjunctiva of both eyes. Fundi were normal. No pulsation or gross exophthalmus was apparent. The systolic bruit was generalized, but maximal over the temporal and orbital areas. It disappeared with digital compression of the right carotid artery. The bruit was not heard over the carotids.

Bilateral cerebral angiography was performed using a single pressure injection of dye into the right brachial artery and two hand injections of dye into the left common carotid artery. The second carotid injection was made with pressure over the right carotid. The right brachial injection (figures 1 & 2) demonstrated filling of the middle and posterior cerebral arteries and very faint filling of the anterior cerebral artery. There was opacification of the right cavernous sinus within one second. The sinus opacified bilaterally and densely. The cavernous sinus drained largely through the ophthalmic vein on the right which was increased in size. This vein then drained into the facial vein and subsequently there was filling of the veins in the neck. No definite aneurysm or precise localization of the fistula between the cavernous portion of the carotid artery and the cavernous sinus was identified. There was no shift of the visualized vessels and the deep veins were in normal position. The left carotid injection was normal.

Operative Report

Through a right anterior craniotomy the internal carotid artery was clipped intracranially proximal to the posterior communicating artery. Muscle embolization of the right internal carotid artery with a silver clip identifying its distal tip was then performed, the muscle being advanced with a ureteral catheter followed by ligation of the internal carotid artery in the neck.[9] Postoperatively a soft bruit was still heard but was no longer obliterated by carotid artery pressure. The conjunctival vessels returned to normal immediately. However, by the next day chemosis and a modest exophthalmus developed, progressing to a very marked degree. This, along with her impaired vision, gradually improved over the next several months. The bilateral exophthalmus and chemosis suggested that the embolus or thrombus had occluded both cavernous sinuses.

Causes

Trauma which produces a fracture of the sphenoid bone and a tear in the adjacent internal carotid artery is the usual cause.[7,8] The remainder are spontaneous and probably aneurysmal in origin.

Clinical and Angiographic Features

The signs and symptoms of a carotid artery — cavernous sinus fistula are 1) a systolic bruit usually best heard over the orbit and the carotid artery on the involved side and disturbing to the patient; 2) frequently there is a pulsating exophthalmus with engorgement of the conjunctival and periorbital veins and a partial or total external and internal ophthalmoplegia. These signs result from arterialized blood entering the cavernous sinus and then into the orbital veins which normally drain the cavernous sinus; 3) gradual loss of vision and anesthesia of the cornea may occur on occasion.

Pain is not a prominent feature of carotid cavernous fistula, although it may precede or be associated with the onset of the spontaneous fistula from a ruptured aneurysm. The shunting of blood from the internal carotid artery into the cavernous sinus, the walls of which are formed by the dura mater, usually prevents blood from entering the intracranial cavity or the cerebrospinal fluid. It is the only location in which an artery passes through a venous channel and prevents blood from gaining access to the subarachnoid space.

There are three common angiographic features of the carotid cavernous fistula: 1) early dense opacification of an unusually enlarged cavernous sinus; 2) early filling of the ophthalmic and other veins normally draining into the sinus and often also the opposite cavernous sinus; 3) variable and poor filling of the cerebral vessels depending on the size of the fistula.

Management

Many surgical methods have been described with varying degrees of success. Multiple operative procedures were described in many of the cases.[17-24, 26-28]

A composite of the success rate of some of these procedures as reported by various authors is as follows: spontaneous cure, 3%, treatment by digital compression, 28%, unilateral ligation of the common carotid, 66%; internal carotid artery ligation, 72%; and those

Figure III

treated by the trapping procedure resulted in a 94% cure rate. A review of the literature by Echols and Jackson, however, is not so optimistic. They reported: "There is a false impression among the medical profession that the rate of cure after ligation of one or more of the arteries in the neck for carotid cavernous fistula is high. The fact is that the rate of cure with this type of operation is less than 50%."[10,11] Muscle embolization alone had not produced the 100% cure rate hoped for, but muscle embolization with proximal and distal ligation of the internal carotid arteries, suggested by Brooks,[11] introduced by Jaeger[12] and advocated by Hamby[13,14] and Dott[8] as a single or as a staged procedure has produced a superb cure rate. A recently introduced gelfoam embolization procedure has also produced favorable results to date but must await more widespread use before definitive evaluation.[17]

In 1935 Dandy concluded from his experiences that total arterial occlusion was permissible only when all other arterial ligations had failed to cure. Two points were made which are especially valuable and pertinent. First, "When one analyzes the results it is quite clear that neither the cures nor the failures are dependent on the isolation of the aneurysm by occlusion of the carotid, but on the development of a thrombus in some part of the vascular apparatus, that is the fistula itself, the carotid artery, or the venous tributaries". Second, "When drainage of the ophthalmic vein has been obstructed, acute and alarming intensification of the exophthalmus and chemosis will occur".[7,26]

In 1949, reporting in the *Southern Surgeon,* Jaeger noted Brooks' attempt at direct closure by introducing a strand of muscle, but felt that the procedure, while directed at a specific cure by directly plugging the carotid cavernous opening, would be unwise because of distal cerebral embolization. Jaeger then described a patient that he treated by a similar procedure, but only after he had clipped the carotid intracranially prior to insertion of the muscle embolus. This prevented the embolization of the cerebral vessels. He performed a craniotomy, placing a silver clip on the internal carotid as it entered the cranial cavity. He then exposed the internal carotid in the neck and introduced into the lumen a muscle embolus to which was attached a silver slip for x-ray identification. The blood flow aided by a small ureteral catheter propelled the embolus to the fistula. Its location was confirmed by x-ray identification of the silver clip at the carotid-cavernous opening. His patient was cured.

The "vagaries" of the dynamics of the carotid-cerebral and carotid-fistula circulation were well illustrated by Hamby in 1964 when he described thirty-two successfully treated cases.[13] He made special reference to the direction of the arterial flow distal to the fistula. "When the fistula develops, a large part of the primary flow is diverted through it. During the stage of collateral development, the flow of the anterior cerebral and ophthalmic arteries reverses to supply the middle cerebral arteries. Contributions from the posterior communicating artery to the collateral vessels expand with time, and effective balance of pressure maintains cerebral flow. Ligation of the common or internal carotid arteries breaks the balance and blood previously supplying the middle cerebral artery is diverted into the fistula segment. The volume of blood entering the sinus is reduced, but the fistula remains patent. The best protection for cerebral circulation is closure of the carotid artery above the fistula. If the ophthalmic vein can be clipped and the proximal carotid artery ligated, the chances of closing the fistula are improved."

The contributions of the external carotid artery to the cavernous sinus fistula, postulated on the basis of the same five branches of the cavernous portion of the internal carotid has been graphically demonstrated by Hayes.[25] The vessels which are capable of developing anastomotic and retrograde flow to maintain the fistula include the 1) corticotympanic, 2) the cavernous, 3) the hypophyseal, 4) the meningeal, and 5) the ophthalmic.[12] With such generous anastomotic vasculature, it is imperative that the method undertaken produce clotting within the sinus.

Hamby recommended a definitive, one-stage operation consisting of clip-

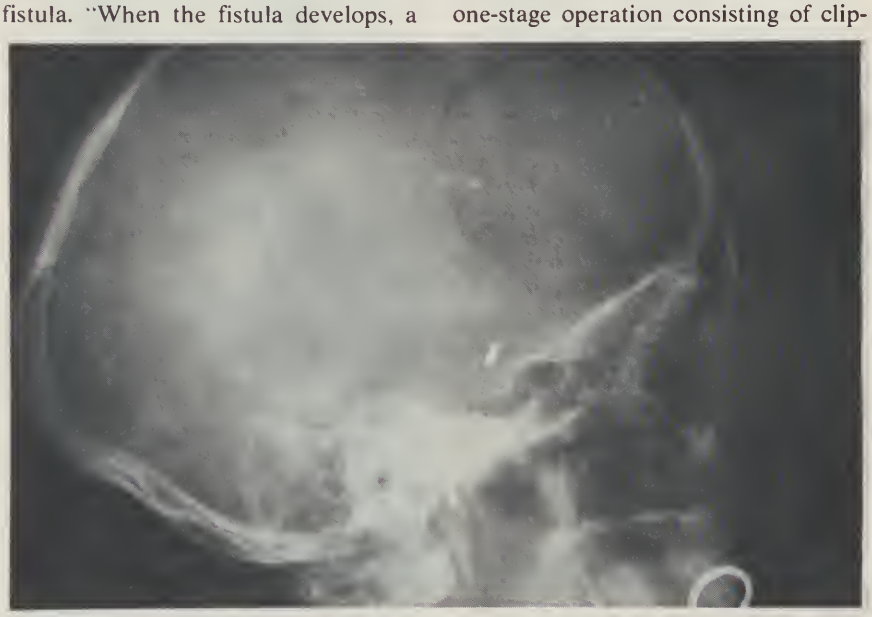

Figure IV

ping the intracranial carotid, followed by embolization of the fistulous carotid segment with muscle and occlusion of the common, the external, and the internal carotid arteries. He further reported that various combinations of progressive, proximal, and distal arterial ligation resulted in a high rate of failure.

In 1965 Speakman's successful use of a porridge-like mixture of gelfoam chopped up gauze, and small metallic markers was reported in one case by Pool and Potts in their monograph on the surgical treatment of carotid cavernous fistula. Additional reports by Ishimori et al using gelfoam and gold film were published in 1967. Krayenbuhl,[19] in his paper published in 1967 describing his own experiences with a review of the literature, advocated muscle embolization and ligation of the cervical internal carotid artery. He avoided ligation of the distal and proximal carotid artery if the angiographic findings demonstrated an intact interhemispheric arterial communication.

A variation of the artificial embolization technique was reported by Kosary in June 1968.[17] He observed that the most effective treatment of carotid cavernous fistula consisted of isolation of the cavernous portion of the internal carotid arteries by ligation in the neck after intracranial clipping of its terminal portion. Because of its hazards, however, this procedure is often avoided and the results correspondingly poor. Their report described the successful intraluminal occlusion of the terminal internal carotid artery by embolization with a porcelain bead, thus eliminating the need for craniotomy. In this procedure they relied on a natural reduction in caliber of the internal carotid artery which occurs in the supraclinoid portion to insure arrest of the embolus distal to the fistula. The size of the bead was selected after direct measurement of the individual's angiogram. Gelfoam was introduced subsequently to hasten clotting in the cavernous portion of the artery in full confidence that it would be arrested there. It would also prevent downward displacement of the bead by the flow from above. It was their intent to use an adequate bulk of Gelfoam, which would swell in situ, to prevent the development of collateral filling. Luessenhop and Spence had previously reported the use of artificial emboli in the treatment of arteriovenous malformations of the brain.[28] Wanissorn has discussed the mechanism of experimental muscle embolization of the carotid-cavernous fistula and the fate of the embolism.[29]

Summary

A case report of the carotid-cavernous fistula is described. A brief summary of the clinical and radiographic findings and a review of the neurosurgical literature regarding the various surgical approaches is presented. This paper represents an endorsement of the muscle embolization technique utilizing the Jaeger maneuver. □

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Felty's Syndrome

The Role of Neutrophils in Inflammation

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The inflammatory cycle appears to be a regular sequence of events involving both cellular and humoral components and generally is independent of the nature of the irritant. Following the identification of a foreign entity, the peripheral circulation responds with a mobilization of inflammatory cells including neutrophils, which have as their main functions phagocytosis, and local acid production. They are able to cause a marked decrease in local tissue pH because of the production of lactic acid, which is capable of killing bacteria in vitro at concentrations of 250 micrograms percent.

Any interference in the normal production of neutrophils in bone marrow or in their transport to a site of inflammation has serious results. There is at best an ineffective cellular component to the inflammatory reaction; there is certainly less efficient handling and containment of an invading population of microorganisms; and lastly, with the deterioration of local tissue integrity, there may be advancement of the infection to systemic proportions. A recently encountered case of Felty's syndrome demonstrates these principles.

Case Report

W.S., a 46-year-old man, entered the hospital because of a chronic leg ulcer of six months' duration. It had begun as a 2 cm lesion following trauma to the anteromedial right leg 5 inches distal to the tibial tubercle. Despite adequate rest of the extremity, elevation, frequent warm, wet soaks, and the use of topical and systemic antibiotics, the ulcer had enlarged so that at the time of admission it measured 5½ inches in its long axis and 2 inches in its transverse axis. (Figure 1) It was painful, indurated, and had a foul odor.

Two other aspects of his history were considered significant. First, he was a known diabetic since age 23, but his diabetes had generally been well controlled on 40 units of globin insulin a day. Second, for the last two years he had noted gradually increasing weakness and had received 5 units of blood in that time for a "chronic anemia."

Approximately three years previously he had a furuncle just anterior to the right ear which spread rapidly to involve the cheek and neck region and resulted in a protracted infection with some loss of tissue and a definite cosmetic deformity.

Figure 1: Right pretibial traumatic ulcer at time of admission.

On physical examination, the previously described ulcer was noted. There was no evidence of diabetic retinopathy. His spleen was palpable 2½ inches beneath the left costal margin. His hematologic studies are summarized in Figure 2; he was noted to have a moderate thrombocytopenia and a definite leukopenia. A differential count revealed a persistent decrease in neutrophils. His initial hemoglobin was 8.9 grams per cent.

On the fifth hospital day an excisional debridement of the ulcer was carried out. His leukopenia persisted and the ulcer site gave no evidence of healing. A sternal bone marrow aspiration showed increased granulocytic activity; all of the other blood elements appeared normal. Because of the occurrence of several episodes of painful joints, particularly in the fingers and toes, x-rays were obtained of the hands and feet and showed typical changes of rheumatoid arthritis. A diagnosis of Felty's syndrome, splenic neutropenia secondary to rheumatoid arthritis, was made, and the patient underwent a splenectomy on the twentieth hospital day. The spleen was approximately five times normal size, weighed 1330 grams, and was not adherent to any adjacent structures. The procedure was accomplished without incident, but because of his prolonged anemia and the presence of a chronic infection of the leg, two additional units of whole blood were given in the recovery room after the patient had regained consciousness.

His white blood cell count and platelets showed an immediate postsplenectomy rise and there was a marked increase in the percentage of polymorphonuclear leukocytes in the peripheral blood smear. The previously indolent ulcer of the right leg improved remarkably. The grayish, friable tissue previously present was replaced by healthy, red, clean granulations, and the wound underwent substantial contraction. The ulcer site appeared sufficiently clean to warrant an attempt at split thickness skin grafting by the thirty-fourth posthospital day (fourteen days after splenectomy). A 100 percent "take" of the graft resulted. (Figure 3)

His course thereafter was uneventful. His temperature remained normal. He was discharged one week

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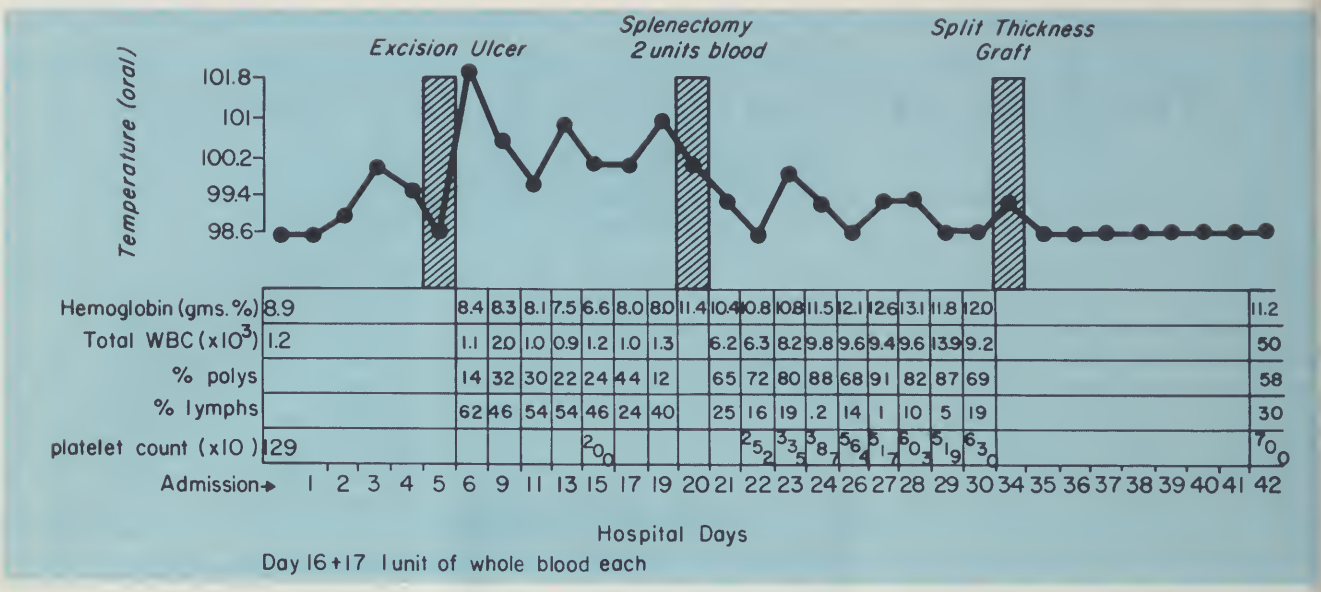

Figure II: Summary of clinical and laboratory course.

after application of the split thickness skin graft.

Discussion

Without entering into controversy as to whether the leukopenia is due to increased systemic sequestration of neutrophils or to the presence of a humoral marrow depressant or both, we may safely say that splenectomy resulted in a rapid increase in circulating neutrophils and was of immediate benefit in the improvement of the chronically infected leg. Review of the literature on Felty's syndrome [2-9] shows our case to be typical in presentation, hematologic and physical findings, and clinical response to splenectomy. Many patients can tolerate a leukopenia with counts between 2,000 and 4,000; however, the invasion of mucous membranes, skin, and blood stream by microorganisms becomes increasingly frequent and severe when the white blood cell count is less than 2,000. In our case, an indolent and increasingly severe ulceration of the skin and subcutaneous tissue, the result of trauma, failed to respond to the routine measures which prove effective in the majority of otherwise normal patients. The ulcer remained necrotic and filled with friable, poorly formed, overgrown granulation tissue. An additional deleterious factor in this case was that in diabetic patients the lower pH of the inflammatory zone is maintained not so much by lactic acid as by acetoacetic and Beta-Hydroxy-Butyric acids,[1] which are much inferior to lactic acid in bacterial suppression in vitro work.

In a very interesting experiment, Page and Good[10] showed that neutropenic rats challenged by subcutaneous injection of a protein antigenic irritant exhibited a dramatic inhibition of the early stages of the inflammatory cycle characterized by minimal perivascular round cell infiltrate, local deficit of macrophages, and delayed lymphocyte infiltration and absence of edema, probably secondary to altered capillary permeability. However, when the irritant was injected with viable inflammatory leukocytes, a normal early appearance of lymphocytes and macrophages occurred, suggesting that the role of the neutrophil was the production or induction of a specific chemotactic substance which marshalled the other components of the inflammatory reaction. Since the methods available for the study of white blood cells are largely morphologic,[11,12] the elucidation of complete descriptions of leukocyte function is still in process. The importance of the leukocyte as an essential element in the sequence of the ordered inflammatory response is, however, quite obvious. □

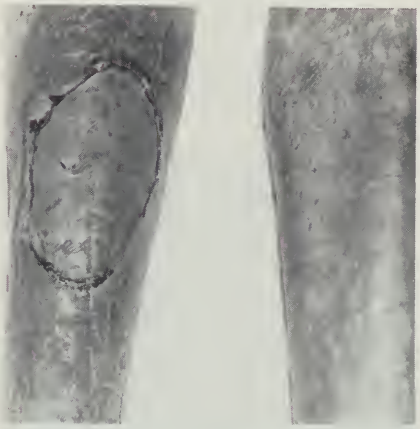

Figure III: Split thickness skin graft to right leg. Picture taken on eighth day after placement of graft.

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Serous Otitis Media

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Serous Otitis Media is an increasingly serious problem in family medical practice. There is a remarkable lack of unanimity as to the cause or treatment of this disorder.[1-3]

In the past, non-purulent otitis media was considered to be a low grade infection, not acute nor painful enough to cause symptoms as in true acute suppurative otitis media.

Among the causes listed by various authors are hypertrophic adenoids or adenoid regrowth or remnants. Other causes are allergic conditions, poor humidification in the home, rhinitis of pregnancy, idiopathic eustachial tubal dysfunction, and endocrine diseases.

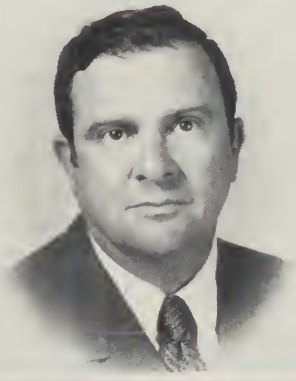
The character of the effusion varies from a frothy serous, through tacky mucous, all the way to "glue"— aptly termed the "glue ear." It is interesting to note that one large series found over one-third of the cultures of these aspirates contained identifiable organisms. Are these problems, in fact, due to the use of chemotherapy and antibiotics? The incidence of the problem has definitely increased in this antibiotic era. Although a cause and effect relationship has not been established, inferential proof is mounting considering the number of acute earaches treated with these agents. The stages of the inflammatory reaction have not changed; only the ability to kill the organism has changed. The complications of suppurative otitis media and mastoiditis are much more life-endangering than all the problems of serous otitis media. There is a rapidly increasing problem of pre-school and school age children with potentially curable but often stubbornly difficult hearing losses.

Treatment

Medical measures, such as endocrine system evaluations, are a rare but definite consideration in treatment.[3] A total allergic assessment, including a careful history and skin test, is vital.[2] Positive identification and subsequent desensitization is indicated for allergic patients.

A vitally important area in all patients with serous otitis media is proper humidity. All doctors should alert patients with respiratory ailments in the cold months of the year to the need for adjunctive humidity in the home. A portable humidifier or vaporizor or a central hot air heat humidifier will promote nasal physiology. The avoidance of excessive mucous production is a major key in avoiding predisposition toward serous otitis media and other recurrent respiratory inflammatory afflictions.

If decongestant effect locally and/or systemically is not successful, a myringotomy with aspiration is mandatory. This is done locally in adults, or with anesthesia in children in the inferior portion of the drum. Since the consistency of the exudate varies, care must be taken during the procedure that the aspiration is sufficiently long to extract all of a potentially thick return. In recent years, due to the frequent recurrence rate of this disease in the same patient, otologists have used plastic tubes which are inserted through the drum for constant areation of the middle ear. The procedure is done after aspiration under general anesthesia in children, and locally in adults. The result is a small (2-3 mm) consistent hole in the drum, not to drain the fluid, but to equalize pressure with the outside environment, and so to prevent the formation of the secretion. These tubes may be left in place as long as is desired, or removed and replaced as indicated. Unfortunately, they may extrude themselves after about six months.



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There remain two other areas of treatment to be considered. One is quite major; namely, adenoidectomy. Lymphoid tissue has a natural ability to swell in the presence of inflammation. In a space such as the nasopharynx, already crowded with adenoids, it does not take much to clog the orifice of the eustachian tube. The resultant absorption of air and resultant negative pressure cause transudation of serum from the capillaries. The result is like the muffler of an automobile— it dampens the hearing. Adenoidectomy and myringotomy are therefore indicated.

Regarding the use of irradiation of the nasopharynx, the consensus of most otolaryngologists is that this is acceptable treatment in certain carefully selected subjects. However, most do not use this course of therapy. The fear is the possibility of incidental production of malignancy in head or face structures.[4] A published report in 1955 of fifteen cases of thyroid carcinoma showed patients had had x-ray treatment in childhood. There has been no literature documentation to substantiate such a result from the application of radium to the nasopharynx. Certainly, in the light of insufficient proof in either direction, it is reasonable to use this therapeutic modality as the last resort.

The practical point, as Davidson has shown,[5] is that "the majority of well-qualified otologists have discarded the use of radium applicators." In his survey of ninety-six otologists, six had

used a radium applicator in the past year, ninety had not. Of those who had not, the most often given reason was that they "saw no benefit from use of the applicator." This is an important concept since all other therapies have a good effect immediately.

Etiology

Is it an endocrine disease or is it a collagen disease as has been theorized by some? What part does allergy play? These questions are all unanswered, and probably therein lies the key to treatment. An important consideration is what the long term result will be if this fluid is not removed from the middle ear. It is accepted by most that the end result is dehydration of the transudate and eventual organization into fibrosis with permanent binding of the ossicular chain and a conductive hearing loss which is irreversible.

Conclusion

Treatment of serous otitis media by antibiotics, eustachian tube inflation, ear drops, nasal decongestants, and antihistimines, is generally ineffective. There is the occasional "blocked ear" which will clear with local or systemic regimes, but a true serous effusion must be aspirated. Myringotomy without aspiration is useless. Recurrence of the fluid in children is avoided in many cases if a concurrent adenoidectomy is performed. This presupposes proper subsequent home humidification and management of any concommitant allergy. Still, approximately 15 percent of those patients who have had this disease once will have a recurrence despite these measures. These cases will usually require indwelling tubes. These are the problems which many otologists consider a scourge and an enigma in their practices. □

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During November 1969, fifteen newly trained library supervisors working for the first time in this capacity in fifteen community hospitals in outlying areas in the states of Maine, Massachusetts, New Hampshire, and Rhode Island requested 163 interlibrary loans of books and journals; filled 37 interlibrary loan requests for other medical libraries; answered 169 general reference questions; scanned 283 periodicals for items of interest to the professional staff at their hospitals; compiled 35 bibliographies by subject; directly consulted or instructed others in the use of *Index Medicus* 208 times; and made 1,410 photo-copies. In addition, these neophyte hospital librarians helped staff physicians and nurses prepare educational programs; assisted in arranging for speakers; scheduled meeting rooms; obtained audio-visual materials; prepared audio-visual equipment, and took minutes at professional meetings.

These same individuals also ordered books and journals; received, processed, and notified staff of new acquisitions; developed card catalogs; formalized and implemented lending procedures and dusted the shelves!

This information would not warrant interest without the knowledge that essentially none of the services were being performed in these hospitals prior to the introduction of the core library development program for community hospitals.

Core Library Program

The core library program began with the idea that it must be possible to develop a small but comprehensive library collection that would be clinically useful in hospitals where busy practitioners weren't using existing materials because they didn't have the time to rummage through the piles of monographs stored in some obscure corner and labelled "library."

Postgraduate Medical Institute (PMI) in Boston, Mass. believed that hospital libraries could indeed be upgraded and that they could grow to become vital tools to support all aspects of education conducted in hospitals. The recent evolution in hospital libraries from quiet, unused archival depositories to busy centers of learning activity for use by all members of the health care team is indeed encouraging.

In 1961, PMI undertook a developmental program whose primary objective was to use educational consultation to encourage community hospitals and their professional staffs to develop their own coordinated programs. In 1967 the Public Health Service awarded PMI a three-year contract to implement a program to train consultants to go into community hospitals to aid with education program develop-

ment. The results of that study were published recently as part of a book entitled: *Continuing Medical Education in Community Hospitals: A Manual for Program Development.*[1] The reports that PMI's physician consultants brought back from forty study hospitals in New England were instrumental in launching PMI's activities in the field of hospital library development. The consultants reported that libraries were virtually non-existent in hospitals, that the collections that did exist averaged twenty years in age, that there were no librarians working in these hospitals and that the only attention given to most of these facilities was custodial. They also reported that physicians, administrators, and directors of medical education and directors of in-service education programs were concerned about these inadequate facilities and were asking what could be done to change them.

The development of the Core Medical Collection[2] was PMI's response to this concern, and it served as a basic stimulus for library development programs in hospitals both in New England and in other regions of the country. The Core Library is the result of a thesis that a hospital library should be comprehensive and balanced yet small enough to be economically feasible as a "package" that is an appealing purchase for hospitals. The Medical Core resulted from the responses of 321 specialists representing 42 areas of medical practice including the basic sciences. These authorities made specific recommendations of books and journals in their own specialty fields appropriate for the use of practitioners in community hospitals.

Integrated Health Science Core Collection

The more recent Integrated Health Science Core[3] collection includes 87 books and 75 journals and represents the recommendations of more than 1,300 specialists in medicine, nursing and other allied health professions. It is recommended as the basic library collection for every community hospital. The cost is about $4,000 and its space requirement is about 40 linear feet of shelving for books and about 90 linear feet for journal display and storage.

This expanded collection supports the concepts inherent in the development of the original core: that (1) all areas of health care practice, including the basic sciences, be covered in the hospital book collection; (2) that a minimal number of high quality journals appropriate to practice should be included; and (3) that all materials should be readily accessible, clearly labeled and logically arranged for use by busy practitioners.

Evolution of the Hospital Library

Traditionally books and journals were contributed to the doctor's library by staff members who needed more shelf space in their offices or at home or by widows of doctors. Sometimes books and journals were purchased by the hospital in response to requests from the most vocal members of the staff or library committee. What resulted was heavily weighted with materials that were either antique or representative of the interests of only a very small portion of the hospital's staff.

The "librarian" was usually someone who worked primarily in another department of the hospital and who had the additional assignment of operating the library. This frequently meant that she went to the library once a week to restack journals and dust books.

This type of library existed only because the Joint Commission on Hospital Accreditation required that every hospital have a library "commensurate with the needs of the hospital staff." A definition of a library or any standards for its maintenance or for the services it should provide were vague. As recently as three or four years ago this picture was reasonably representative of the status of libraries in community hospitals. These facilities were called "medical" or "doctors" libraries and the use of them by other health care personnel such as nurses and laboratory technicians was actually discouraged.

It is not fair to describe all community hospital libraries so dismally. There were examples of libraries where collections, services and facilities had been viable and therefore well used over the years. Libraries in hospitals at academic centers had been rigorously developed, because teaching and research took place at these centers and the library users naturally demanded that everything they needed be available when they wanted it. Formal teaching and research in the communities away from the medical centers was done on a minimal scale and thus, theoretically, the library users were not making demands equal to those that were heard in academia.

Medical Library Assistance Act

Public Laws 89-239 (for Regional Medical Programs) and 89-291 (for Regional Medical Libraries) made important impacts on the evolution of hospital libraries. One of the major missions of regional medical programs (RMP) has been to study the availability of services, facilities and manpower to deliver optimal care and preventive measures in the categorical areas of heart disease, cancer and stroke. Since most RMPs have viewed hospital libraries as supportive resources for education and patient care programs, they have initiated programs to improve hospital libraries.

The Congress also recognized the problem of maintaining and retrieving the overwhelming masses of biomedical literature and sensed the urgency of making this information available to all practitioners, not just those at medical centers. The Medical Library Assistance Act therefore established regional medical libraries to serve as centers to collect, maintain and disseminate biomedical information throughout each designated region. There are now eleven regional medical libraries, and each of these has a program to improve the libraries used by practitioners at the hospital level. Regional medical libraries and regional medical programs have thus begun to approach hospital library development as an important aspect of their programs, and they have done so at about the same time. Their cooperative and concerted approaches are making very positive contributions to the evolution of hospital libraries.

Revised Hospital Accreditation Requirements

Another important influence has been a revision of the Joint Commission on Hospital Accreditation's requirements and expectations for hospital libraries. The new standards,

effective July 1, 1970, require these three specific library functions: 1) reference service, 2) document delivery service, and 3) audio-visual services.[4] These activities obviously cannot be performed on a casual basis by someone who has no special training for the job or who has no special interest in the library. Furthermore, these functions cannot be performed without certain basic and comprehensive materials that were not usually included in the hospital library of the past.

The Vital Link

As a result of the RMP and RML programs for hospital libraries, a new health professional is being trained. In the New England Region they are called "Library Supervisors" and they are beginning to fill a critical manpower gap. Perhaps hospital libraries were long neglected because there weren't enough professional medical libraries to go around.

No library can service its patrons effectively if there is no librarian responsible for doing so. A part-time, non-professional, but specially trained "library technician," "supervisor," or "assistant," becomes the vital link between health practitioners in the hospital and the information available at his hospital plus that which can be obtained from the entire universe of biomedical literature by means of recently developed and newly implemented access devices.

A broadening of attitudes about who should use hospital libraries is another positive change and reflects a change in attitude about actual approaches to patient care, since it is now recognized that the total care of patients involves virtually everyone who works in the hospital. If nurses, lab technicians, dieticians, administrators, etc. do contribute (directly and indirectly) to the care of patients, should they not be reading and learning together as they do so?

These direct influences on library development in hospitals plus the fact that all health professionals are under more and more pressure to learn the latest advances in medical science encourage the evolution of health learning centers as viable departments in every hospital. PMI and the New England Regional Medical Library Service at the Francis A. Countway Library of Medicine in Boston have now trained more than 100 library supervisors. The library training program in no way attempts to condense a master's level library science course into a five-day workshop. Instead focus is on the most practical elements of working in a hospital library— those elements that can lead health professionals into the entire world of biomedical information.

Traditional "library" functions are being assumed for small hospital libraries by large medical libraries where the capabilities for such performance can be coordinated. The Medical Library Assistance Act has legislated a program to centralize certain activities so that they can be accomplished practically and so that a network of library services can be established.

Role of the Nonprofessional Librarian

The library institutes in New England and in other parts of the country have produced a new health manpower— a nonprofessional "librarian" who has been trained to provide essential library service.

The hospital library is now ready for a next important step in its evolution toward the ultimate goal of service as a health learning center. This next step involves the utilization of the librarian as an assistant to the hospital educator so that the functions of the education and the library programs can be merged.

Consider, for example, this list of activities that the librarian might perform in the interest of the hospital education programs. It includes monitoring current periodicals for articles relevant to the topics of scheduled education programs, verifying citations obtained by speakers, preparing bibliographies listing sources of information relevant to topics of speakers, copying essential literature for all participants, arranging for interlibrary loan of topic materials if necessary, and reviewing medical education literature and obtaining reprints for a resource file for the hospital educators.

In addition the hospital library supervisor could be trained to assist with certain aspects of education program development. These activities could be logical extensions of the "library" work. A librarian and her staff might keep a schedule of room availability and use for education programs, prepare notices of all sessions and deliver them to potential participants, maintain the hospital educator's master calendar of educational activities, prepare travel directions to the hospital for outside participants, prepare and mail letters of invitation and follow-up notices for guest participants, prepare and distribute publicity releases about education sessions, arrange for necessary audio-visuals prior to each session, distribute and review session evaluation forms, and send honoraria and thank you letters to participants.

The scope of this new position called "Health Information Assistant" might be thought too broad for one person. That may be so. The library in hospitals may be growing beyond a one-man operation. If this is so, a tremendous evolution over a very short span of time has occurred. Most significantly, centering education activities in the library will call attention to the library's ability to respond as an active and vital information source in the hospital. □

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1. **Stearns, N.S., Getchell, M.E., and Gold, R.A.** Continuing medical education in community hospitals: a manual for program development. Massachusetts Medical Society: New England Journal of Medicine. Boston, 1971.
2. **Stearns, N.S., and Ratcliff, W.W.** A core medical library for practitioners in community hospitals. NEJM 280:474-480, 1969.
3. **Stearns, N.S., and Ratcliff, W.W.** An integrated health-science core library for physicians, nurses and allied health practitioners in community hospitals. NEJM 283: 1489-1498, 1970.
4. **Joint Commission on Accreditation of Hospitals.** Accreditation manual for hospitals. pp. 129-131. Chicago, 1971.

Mrs. Fink is presently a technical associate working on special projects at the Countway Library, and Dr. Stearns is director of Tufts Medical Service at Boston City Hospital. Formerly Mrs. Fink was director of the library development program at the Postgraduate Medical Institute in Boston, and Dr. Stearns was PMI's executive director during the developmental stages of the Core Library Program. PMI is a non-profit education corporation funded by a number of sources including the Division of Physician Manpower, NIH, U.S. Public Health Service, the National Library of Medicine, and the Tri-State RMP. Mrs. Fink delivered the paper at recent PMS conferences on hospital library management.

PENNSYLVANIA MEDICINE cardiovascular brief

Acute Myocarditis
Part 1

Joseph B. Cady, M.D., Cardiologist, Guthrie Clinic, Ltd., Sayre, Pennsylvania, is questioned by William G. Leaman, Jr., M.D.

What conditions do you include under this title?

We can place in this category any inflammatory myocardial change following infectious or contagious diseases (bacterial, viral, fungal or helminthic). Myocarditis may occur at any age and is not the result of coronary artery disease, hypertension, congenital or acquired valvular disease.

What viral diseases may give rise to acute inflammatory myocardial changes?

Here we include infectious parotitis, varicella, variola, vaccinia, influenza, viral pneumonia, infectious mononucleosis, and poliomyelitis.

What changes can occur in the heart muscle of these patients?

Histological examination of the myocardium at necropsy in isolated patients has shown microscopic perivascular and interstitial infiltration of lymphocytes, plasma cells, and especially polymorphonuclear leucocytes. Some necrosis and fragmentation of the muscle fibers may also be seen. These changes suggest that the process is part of the more general disease affecting the patient.

Can the offending virus be isolated from the heart at necropsy?

Only rarely. However, isolation of the poliomyelitis virus from the heart in fatal cases has been reported. In addition, Coxsakie B virus appears to be especially cardiotropic.

What cardiac signs and symptoms suggest involvement of the heart?

Cyanosis, dyspnea, and tachycardia are findings that usually direct attention to the heart. Vascular collapse, pulmonary edema, and hypertension may also follow with the latter usually being related to hypoventilation and hypoxia.

On physical examination what further evidence of acute myocarditis may be encountered?

Cardiac enlargement may appear and arrhythmias are not uncommon. In viral diseases the muscle of the heart is most frequently involved and may be seriously affected. A friction rub may be found in these patients. Therefore, serial electrocardiograms during the course of the illness will usually reflect the extent of the damage.

What ECG changes should be looked for?

Abnormally high or peaked P-Waves may appear, together with some arrhythmias. Major changes often are found in the P-R Intervals, the RST segments, and the T-Waves, which may be flattened, diphasic or inverted.

Are previously damaged hearts more vulnerable to viral infections?

I believe so. This may be because of some alteration in the heart that makes it more susceptible or favorable to viral growth.

What is the prognosis of the cardiac involvement if the patient survives the primary viral infection?

With patient survival, it has been the general belief that cardiac disability lessens as symptoms and signs of the viral infection fade. Perhaps this explains the survival of such terms as "idiopathic", "benign", "Fiedler's myocarditis", etc., in our literature. However, residual cardiac enlargement has been encountered in some patients following an episode of viral infection. A number of viruses may invade at one time or another and furnish positive evidence of the presence of acute myocarditis, pericarditis, and endocarditis. As some believe, a continuing lesion may be the result of a coexisting deprivation of oxygen to the heart.

Is acute myocarditis encountered during or following influenzal outbreaks?

Acute myocarditis has been reported during the course of inflenza A pneumonia and recent epidemics of "Asian" infleunza. Again, a wide variety of infectious disease may involve the heart and initiate an inflammatory process. However, cardiac involvement is usually subclinical and readily overlooked. For this reason, the exact incidence of acute myocarditis is impossible to ascertain as most patients recover spontaneously. Laboratory and clinical findings may be variable and non-specific. Acute myocarditis is not a difficult diagnosis to make when the primary disease is severe. However, we should always suspect such a complication even in mild infections and carry out appropriate laboratory studies during and following the infection.

What is the treatment of acute myocarditis complicating a viral infection?

In these several kinds of myocarditis, specificity for any form of treatment hardly exists, and attention is paid to the general condition which has incidentally involved the heart. Such therapy includes the use of antibiotics or cortisone and its allied preparations.

This Brief is edited by William G. Leaman, Jr., M.D., for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.

PENNSYLVANIA MEDICINE cancer forum

Radiation Therapy of Cancer

Tumor Sensitivity and Resistance Part 2

Last month the Cancer Forum discussed tumor sensitivity and resistance as presented by Rubin and Poulter of the University of Rochester. This discussion concerns curability of tumors by radiation.

Certain types of tumors can be cured by radiation; a fact that makes the decision to use surgery, radiation or chemotherapy a very important one. In making the choice three factors are considered: the general condition of the patient, the extent of the tumor, and a factor the radiologist calls the therapeutic ratio.

The age, state of nutrition, presence or absence of debility, and coexisting disease may determine the type of treatment used. The part played by the natural immunity of the patient is debatable at present but considered of importance. Controlling or eradicating the primary tumor often allows the body to then control the metastases. Experimental re-injection of irradiated tumor into the host has increased the radioresponsiveness of the malignant tissue still present.

It is important to know, as accurately as possible, how far the tumor has spread. The curability, while improved with the newer equipment, is still more likely with small cancers without regional lymph node involvement.

The therapeutic ratio is the relationship between the normal tissue tolerance dose (NTTD) and the tumor lethal dose (TLD). The first is that dosage which would cause irreversible damage to normal tissue if exceeded. This varies not only with the type of tissue but the sensitivity of the host. The tumor lethal dose is that amount that will destroy the particular tumor. Here again is much variation. The same tumor in different sites will vary in response and there will also be variation among different individuals. If the tissue tolerance dose exceeds the lethal tumor dose, the tumor is probably curable. If the lethal dose exceeds that of tissue tolerance, the tumor is probably incurable with radiation. On this basis the radiologist classifies neoplasms into three groups: radiocurable, radiotreatable, and radioresistant.

In the curable group are those of embryonal origin; seminoma, dysgerminoma and Wilm's tumor. The reticuloendothelial neoplasms: lymphosarcoma, Hodgkin's disease, and Ewing's tumor of bone are here as well as are the neurogenic tumors: medulloblastoma, retinoblastoma and neuroblastoma of the adrenal medulla.

There are some tumors in the curable group less sensitive than the above but often curable. They include squamous cell carcinoma of the skin, oral cavity, larynx, uterine cervix, and upper esophagus. Transitional cell carcinoma of the bladder, pituitary adenomas, adenocarcinoma of the prostate, and nasopharyngeal cancer are also in this group.

In the radiotreatable cancers the tissue tolerance and lethal tumor doses are so evenly balanced that surgery is usually considered first. This is sometimes combined with or followed by radiation to secure increased survival or improve its quality. Examples would be cancers of the breast, lung, uterine fundus, ovary, rectum and thyroid. In this group also are glioma, renal cell cancer, and cancers of the pasanasal sinuses and salivary glands.

The radioresistant neoplasms are osteogenic, chondro- and fibrosarcoma; melanoma and adenocarcinoma of stomach, pancreas, and colon.

CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health. The Cancer Forum is edited by Roland A. Loeb, M.D., Lancaster.

Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Many patients on special diets will find soups they can enjoy among the more than 50 different varieties available.

Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

When diarrhea wrings the wedding belle...

It's all very well to counsel patience in diarrhea patients. There are times when relief of symptoms can't come too soon.

X-ray studies[1] in 16 normal subjects showed just how promptly the active ingredient in Lomotil does its work.

Lomotil retarded gastrointestinal motility particularly during the first three hours after administration. It continued its moderating action on the bowel for at least three hours more.

Physicians prescribe Lomotil more often than any other drug when the urgency for the control of diarrhea is most distressing.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.

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Each tablet and each 5 cc. of liquid contain:
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Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is classified as a Schedule V substance by Federal Law with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages

should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended average initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:
3-6 mo.... ½ tsp.* t.i.d. (3 mg.)
6-12 mo... ½ tsp. q.i.d. (4 mg.)
1-2 yr..... ½ tsp. 5 times daily (5 mg.)
2-5 yr.....1 tsp. t.i.d. (6 mg.)
5-8 yr.....1 tsp. q.i.d. (8 mg.)
8-12 yr....1 tsp. 5 times daily (10 mg.)
Adults:....2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

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INTERMITTENT COURSES

Listed below are courses of continuing medical education which include a series of two or more sessions on various subjects to determine the specific topic on any given day, contact the director at the address given in the course listing.

CODE KEY

S—Designed for full-time specialists
AAGP—American Academy of General Practice
ACGP—American College of General Practitioners in Osteopathic Medicine and Surgery
AMA—AMA Accredited Educational Institution (Eligible for AMA Physician's Recognition Award Credit)
PMS—Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
M.S. Hershey—Pennsylvania State University College of Medicine, Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Pitt—University of Pittsburgh School of Medicine
Penn State—Pennsylvania State University
Temple—Temple University School of Medicine
U. of Pa.—University of Pennsylvania School of Medicine
MCP—The Medical College of Pennsylvania

CARDIOVASCULAR DISEASES

Pittsburgh; January 17 - February 7, 1972
AMA — Cardiac Auscultation and Examination; by Pitt; at Presbyterian-University Hosp.; 2½ hrs. per day; 1 day per week; 4 weeks; 10 hrs AAGP credit requested; fee=$100. Contact William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt, 1022-H Scaife Hall, Pittsburgh 15213.

Sayre; June 28, 1971 — February 1, 1972
Rotating Specialty Seminar/Cardiovascular Disease; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 17 weeks; 17 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

DERMATOLOGY

Sayre; August 10, 1971—June 6, 1972
Rotating Specialty Seminar/Dermatology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 6 weeks; 6 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

ENDOCRINOLOGY

Sayre; July 20, 1971—May 23, 1972
Rotating Specialty Seminar/Endocrinology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 9 weeks; 9 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

FAMILY MEDICINE

Hershey; September 28, 1971—June 27, 1972
Newer Aspects of Family Medicine; at Hershey; 1 hr. per day; 1 day per week; 40 weeks; 40 hrs. AAGP credit approved. Contact Thomas L. Leaman, M.D., Chrm., Dept. of Family & Community Medicine, M.S. Hershey, Hershey 17033.

GASTROENTEROLOGY

Philadelphia; March 3 - April 7, 1972
AMA — Gastroenterology Seminar (Basic Concepts in the Modern Diagnosis & Management); at Hahnemann; 3½ hrs. per day; 1 day per week; 6 weeks; 21 hrs. AAGP credit requested; fee = $60. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

GENERAL MEDICINE

Abington Memorial Hospital; January 20—March 21, 1972
Endocrine Problems in Family Practice; by Montgomery County Academy of Family Practice; 2½ hrs. ea. day; 1 day ea. week; 10 weeks; 25 hrs. AAGP credit requested; max. enrollment = 30; fee = $25. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Allentown Hospital; September 9, 1971 - June 8, 1972
AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; 1 day ea. mo.; 3 hrs. ea. day; 30 hrs. AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Altoona Hospital; October 7, 1971 - May 18, 1972
AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; 2 days ea. mo.; 2 hrs. per day; AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bethlehem; September 16, 1971 - May 18, 1972
AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; at St. Luke's Hosp.; 1 day ea. mo.; 3 hrs. per day; AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Bradford; October 19, 1971 - May 16, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; at Penn Hills Club; third Tues. ea. mo. except Dec. and Jan.; 18 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt., Scaife Hall, Pittsburgh 15213.

Chester; September 7, 1971—May 23, 1972
AMA— Continuing Education Program; at Crozer-Chester Med. Center; by Hahnemann; 2 hrs. per day; 1 day per week; 38 weeks; 76 hrs. AAGP credit requested; 76 hrs. ACGP credit approved. Contact Frederick K. Heath, M.D., D.M.E., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Coatesville VA Hospital; September 23, 1971—May 25, 1972
The Laboratory and the Clinician; 1 hr. a day; 1 day per mo; 9 hrs. AAGP credit requested. Contact John C. Cottrell, M.D., Chief, Laboratory Services, Coatesville VA Hosp., Coatesville 19320.

DuBois Hospital; February 10 - April 13, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; Thurs. ea. week; 30 hrs. AAGP credit requested, fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

East Stroudsburg; October, 1971 - April, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and M.C. of Pa.; at General Hosp. of Monroe County; 3 hrs. per day; 1 day per mo.; 6 mos.; 18 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Easton Hospital, September 15, 1971 - June 21, 1972
AMA— What's New in Basic Concepts of Each Sub-Division of Medicine; by Hahnemann; 1½ hrs. per day; third Wed. ea. mo.; 12 hrs. AAGP credit approved. Contact Horace Y. Seidel, M.D. Dir., Dept. of Medicine, Easton Hosp., 21st & Lehigh Sts., Easton 18042.

Erie; September 16, 1971-May 12, 1972
AMA — A Program of Continuing Medical Education; at St. Vincent Hospital; by Jefferson and Penn State; 3 hrs. per day; 1 day per week; 12 weeks; 36 hrs. AAGP credit approved. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Gettysburg; January 11 - April 19, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; at Annie Warner Hospital; every-other week, alternating Tues. and Wed.; 24 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Hanover General Hospital; October 20, 1971 - May 18, 1972
Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; one ea. mo. except Jan. and Feb.; 12 hrs. AAGP credit requested. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Harrisburg; September 30, 1971 — January 20, 1972
Continuing Education Program 1971-1972; at Community General Osteopathic Hosp.; 8 Thurs.; 2½ hrs. per day; fee = $60 ($10 ea. single session); AAGP and ACGP credit requested. Contact Charles M. Worrell, D.O., D.M.E., Community Gen. Osteopathic Hosp., 4300 Londonderry Rd., Harrisburg 17109.

Hazleton State General Hospital; September 1 - June 1
AMA (required credit) — A Program of Continuing Medical Education; by U. of Pa.; 1½ hrs. ea. day; Thurs. ea. week; 36 weeks; 54 hrs. total; 40 hrs. AAGP credit approved. Contact Robert Gunderson, M.D., D.M.E., Hazleton State Gen. Hosp., Hazleton 18201.

Johnstown; September 23, 1971 - March 9, 1972
AMA — A Program of Continuing Medical Education; at Conemaugh Valley Memorial Hosp.; by Jefferson and Penn State; 7 sessions; 2 hrs. AAGP credit approved for ea. session. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lancaster General Hospital; September 2 - December 16, 1971
Ambulatory Health Care Conferences; 1½ hrs. ea. Thurs. (except Thanksgiving); 15 hrs. AAGP credit approved; no fee. Contact John H. Esbenshade, Jr., M.D., D.M.E., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17604.

Lancaster General Hosp.; September 7, 1971 - May 30, 1972
Continuing Education Program; 1 day per week; 3 hrs. per day; 29 days; AAGP credit requested; fee = none. Contact John H. Esbenshade, Jr., M.D.,

Dir. Med. Educ., Lancaster General Hosp., 555 N. Duke St., Lancaster 17604.

Lancaster Osteopathic Hospital; September 23, 1971 - May 25, 1972

AMA — Continuing Education Program; by Hahnemann; 2 hrs. per day; 1 day per week; 17 weeks; 34 hrs. AAGP and ACGP credit requested. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Lebanon; November 3, 1971 - May 2, 1972

AMA — A Continuing Medical Education Program; by Jefferson and Penn State; at Quentin Riding Academy; 1 day every-other mo.; 2 hrs. per day; 8 hrs. AAGP credit requested; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Lewistown Hospital; February 9 - April 12, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; every Wed.; 30 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Lock Haven Hospital; October 20, 1971 - April 19, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS and Susquehanna Valley RMP; first and third Wed. except holidays; 30 hrs. AAGP credit requested, fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Meadville; September 1, 1971 - May 3, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS; at Meadville City Hosp.; first Wed. ea. mo.; 18 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Philadelphia; September 15, 1971 - May 17, 1972

Continuing Medical Education Seminars; at Methodist Hospital; 1 day ea. mo.; 2 hrs. per day; 18 hrs. AAGP credit requested; fee = none. Contact John N. Giacobbo, M.D., D.M.E., Methodist Hosp., 2301 S. Broad St., Philadelphia 19143.

Philadelphia; January 4 - May 16, 1972

AMA — Current Topics of Interest to the Family Physician; at Jefferson; 2 hrs. per day; 1 day per week; 20 weeks; 40 hrs. AAGP credit requested; fee = $150. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Pittsburgh; August 5, 1971 - June 22, 1972

Post Graduate Medical Education Lectures; at St. Margaret Memorial Hosp.; first, second and third Thurs. ea. mo. except July; 1 hr. per day; AAGP credit requested; min. enrollment = 30; fee = none. Contact Paul W. Dishart, M.D., D.M.E., St. Margaret Memorial Hosp., 265 - 46th St., Pittsburgh 15201.

Pittsburgh; September 2, 1971 - June 15, 1972

Psychiatry Seminars in Family Practice; at St. Margaret Memorial Hosp.; 1 day ea. week; 2 hrs. ea. day; 32 weeks; min. enrollment 6; AAGP credit requested; fee = $50 for ea. 10-week series. Contact Paul W. Dishart, M.D., D.M.E., St. Margaret Memorial Hosp., 265 46th St., Pittsburgh 15201.

Pittsburgh; October 17, 1971 - March 19, 1972

AMA — Workshops in Medicine; at Western Pennsylvania Hospital; 6 AAGP credit hrs. for ea. course — 6 in series; fee = $20 ea. course (no fee for residents, interns and medical students), luncheon included. Contact Postgraduate Education Secretary, House Staff Office, Western Pennsylvania Hosp., 4800 Friendship Ave., Pittsburgh 15224.

Pittsburgh; October 21, 1971 - June 1, 1972

Seminars for the Primary Physician; at Pitt; 2 hrs. ea. evening; 1 day per week; 27 weeks; 54 hrs. AAGP credit requested; fee = $10 per session ($150 for all 27). Contact William M. Cooper, M.D., Dir., Div. of Cont. Educ., Pitt, 1022-H Scaife Hall, Pittsburgh 15213.

Pittsburgh; July 14, 1971 - June 23, 1972

Post Graduate Medical Education Lectures — Family Practice; at St. Margaret Memorial Hosp.; every Wed.; 1 hr. ea. day; AAGP credit requested; min. enrollment = 20; fee = none. Contact Paul W. Dishart, M.D., D.M.E., St. Margaret Memorial Hosp., 265 - 46th St., Pittsburgh 15201.

Pottsville Hospital; September 2, 1971 - June 1, 1972

AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; first Thurs. ea. mo.; 2 hrs. ea. day; 20 hrs. AAGP credit approved; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Reading; September 28, 1971 - May 23, 1972

1971-1972 Continuing Education Program; at St. Joseph's Hosp.; 4th Tues. of ea. mo. except Dec.; 1 hr. ea. day; 8 hrs. AAGP credit approved. Contact Kenneth M. Schreck, M.D., Med. Dir., St. Joseph's Hosp., Reading 19610.

St. Marys; September 26, 1971 - March 26, 1972

Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust); by PMS, Pitt and Western Pa. RMP; at Andrew Kaul Memorial Hosp.; forth Sun. ea. mo. except December; 21 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt, Scaife Hall, Pittsburgh 15213.

Scranton; Fourth Wednesday of each month (except November, December & June)

A Program of Continuing Medical Education; at Casey Inn; by Lackawanna Co. Med. Society and Greater Delaware Valley RMP; 3 hrs. ea. evening; AAGP credit requested. Contact R.N. Shoemaker, Ph.D., Coordinator of Med. Educ., VA Hosp., 1111 E. End Blvd., Wilkes-Barre 18703.

Sellersville; September 22, 1971 - June 15, 1972

AMA — Continuing Education Program; at Grand View Hosp.; by Hahnemann; 2 hrs. per day; 1 day per mo.; 9 months; 18 hrs. AAGP and ACGP credit requested. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Sharon General Hospital; October 20, 1971 - March 1, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; first and third Wed. ea. mo.; 30 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt, Scaife Hall, Pittsburgh 15213.

Somerset Community Hospital; Fourth Tuesday of each month

A Program of Continuing Medical Education; by Western Pa. RMP and the Regional PG Medical Faculty Project of Lee Hospital, Johnstown; 2 hrs. ea. day; 24 hrs. AAGP credit requested ea. year. Contact William W. Ayres, M.D., Pathologist, Somerset Community Hosp., 225 S. Center Ave., Somerset 15501.

Tunkhannock; March 8 - May 10, 1972

Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust); by PMS and Greater Delaware Valley RMP; at Tyler Memorial Hosp.; second Wed. ea. mo.; 9 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Uniontown Hospital; September 22, 1971 - February 23, 1972

Current Medical and Surgical Concepts (A Pennsylvania Medical Continuing Education Program); by PMS, Pitt and Western Pa. RMP; every-other Wed. except Dec. and Jan.; 24 hrs. AAGP credit requested; fee to be announced. Contact William M. Cooper, M.D., Dir. of Cont. Educ., Pitt, Scaife Hall, Pittsburgh 15213.

Wellsboro- September 15, 1971 - March 15, 1972

Current Medical and Surgical Concepts (An Edward Walter Clark Memorial Education Program of the Educational and Scientific Trust) by PMS and Susquehanna Valley RMP; at Soldiers and Sailors Memorial Hosp.; third Wed. every-other mo.; 12 hrs. AAGP credit requested; fee to be announced. Contact PMS (Continuing Education), 20 Erford Rd., Lemoyne 17043.

Williamsport Hospital; September 10, 1971 - March 10, 1972

AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; second Fri. ea. mo. except Jan.; 3 hrs. ea. day; 18 hrs. AAGP credit requested; fee = none. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

York Hospital; September 16, 1971 - April 27, 1972

AMA — A Program of Continuing Medical Education; by Jefferson and Penn State; Thursday each week; 3 hrs. per day; AAGP credit approved; 30 weeks; fee = $50 ($10 ea. session). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

HEMATOLOGY

Sayre; July 12, 1971 - June 5, 1972

Rotating Specialty Seminar/Hematology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 15 weeks; 15 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

INTERNAL MEDICINE

Abington Memorial Hospital; September 2 - December 16, 1971

S-Recent Advances in Internal Medicine; 2 hrs. per day; 1 day per week; 15 weeks; max. enrollment = 40 (internal medicine) fee = $30. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Philadelphia; October 6, 1971 - May 31, 1972

AMA — Internal Medicine Reviews; at Hahnemann; 3 hrs. ea. day; 1 day ea. week; 32 weeks; 96 hrs. AAGP credit approved; $175 fee ($50 ea. sub-specialty — Hematology & Medical Oncology, October 6 to November 17; Gastroenterology, November 24, 1971 to February 9, 1972, Dermatology & General Topics, February 16 to April 19; Cardiology, April 26 to May 31). Contact Mrs. Sage Cordell, Asst. Dir. PG Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

MALIGNANT DISEASE

Reading; Fourth Tuesday ea. month

Tumor Conference; at Community General Hospital. Contact Harold I. Farber, M.D., Dir., Tumor Clinic, Community Gen. Hosp., 145 N. Sixth St., Reading 19601.

NEPHROLOGY

Sayre; September 13, 1971 - May 29, 1972

Rotating Specialty Seminar/Nephrology; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 9 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

NEUROLOGY

Sayre; August 9, 1971 - March 21, 1972

Rotating Specialty Seminar/Neurology; at Roobert Packer Hosp.; 1 hr. per day; 1 day per week; 9 weeks; 9 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

Norristown State Hospital; September 13, 1971 - May 8, 1972

Intensive Review of Neurology; 1¼ hrs. per day; 1 day per week; 30 weeks; min. enrollment 8; fee = $100. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

OBSTETRICS & GYNECOLOGY

Pittsburgh; (dates by arrangement)

Workshops in Family Planning; by Pitt; at Magee-Womens Hosp.; 3½ hrs. per day; 1 day per week; two successive Fridays; 7 hrs. AAGP credit requested; fee=$50. Contact Marvin C. Rulin, M.D., Magee-Womens Hosp., 3400 Forbes St., Pittsburgh 15213.

OPHTHALMOLOGY

Abington Memorial Hospital; September 22,

1971—May 22, 1972
S-Recent Trends on Ophthalomology; 1½ hrs. per day; 1 day per mo.; 9 mos. 13 hrs. total; max, enrollment=15; fee=none. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

PHARMACOLOGY

Philadelphia; September 27, 1971 - January 24, 1972
AMA — Experimental Design, Statistics and Fortran; at Hahnemann; 2 hrs. per day; 2 days per week; 15 weeks; 58 hrs. AAGP credit requested; fee = $300. Contact Frederick K. Heath, M.D., Dir. Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia General Hospital; September 29, 1971 - May 31, 1972
AMA — Current Concepts in Clinical Pharmacology; by Hahnemann and American Society for Clinical Pharmacology and Therapeutics; 3 hrs. per day; 1 day per week; 35 weeks; 105 hrs. AAGP credit requested; fee=none. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

PSYCHIATRY

Abington Memorial Hospital; September 27, 1971—June 12, 1972
S-Seminar in Psychiatry; 1½ hrs. per day; 2nd and 4th Mon. ea. mo., 10 mos.; max. enrollment=30; fee=none. Contact William H. Mahood, M.D., Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Abington Memorial Hospital; March 7—May 9, 1972
S-Marital Therapy; 2 hrs. per day; 1 day per week; 10 weeks; max. enrollment=20; fee=$50. Contact William H. Mahood, Dir. of Post-Graduate Education, Abington Memorial Hosp., 1200 York Rd., Abington 19001.

Danville; September 8, 1971 - April 12, 1972
AMA — Psychiatry and Community Mental Health; at Geisinger Med. Center; by The Institute of Pa. Hosp., PMS and PAGP; 2 hrs. per day; 1 day per week; 5 weeks; 12 hrs. AAGP credit requested; fee=$5. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Easton Hospital; September 27, 1971 - June 26, 1972
AMA — Psychiatry in Medical Practice; by Hahnemann; 1½ hrs. per day; 1 day per mo.; 9 mos.; 13½ hrs. AAGP credit requested; fee=none. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

PSYCHIATRY

Harrisburg Polyclinic Hospital; November 12, 1971 - May 5, 1972
AMA — Continuing Education Program in Psychiatry for the Clinician; 1 hr. ea. day; 1 day per week; 20 weeks; 20 hrs. AAGP credit approved; fee=$5. Contact John M. Hume, M.D., Chief, Dept. of Psychiatry, Harrisburg Polyclinic Hosp., Harrisburg 17105.

Lancaster General Hospital; November 24 - December 15, 1971
AMA — Sexual Problems in Family Medicine; by Hahnemann; 1½ hrs. ea. Wed.; AAGP credit approved; no fee. Contact John H. Esbenshade, Jr., M.D., D.M.E., Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17604.

Norristown State Hospital; September 10, 1971 - May 12, 1972
S — Intensive Review of Psychiatry; 1¼ hrs. per day; 1 day per week; 31 weeks; min. enrollment=8; fee=$100. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown State Hospital; January 7 - February 18, 1972
S — Management of Adolescent Behavorial Disorders; 1½ hrs. per day; 1 day per week; 7 weeks; min. enrollment=8, fee =$30. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown State Hospital; March 3 - May 19, 1972
S— Family Therapy II; 1½ hrs. per day; 1 day per week; 10 weeks; min. enrollment=8; fee=$50. Contact John D. Pruitt, M.D., Dir., Program for Cont. Educ. for Psychiatrists, Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19401.

Norristown; (dates to be announced)
AMA— Drug Abuse and Alcoholism; at Montgomery Co. Mental Health Clinics; by The Institute of Pa. Hosp., PMS and PAGP; 2 hrs. per day; 1 day per week; 12 weeks; 24 hrs. AAGP credit requested; fee=$25. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; September 7, 1971 - June 6, 1972
S/AMA — Advances in Psychiatry and Behavorial Sciences; by Institute of Pa. Hosp. and U. of Pa.; at the Institute; 1½ hrs. ea. day; 1 day ea. mo.; 10 mos.; fee=$50. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 6, 1971 - February 16, 1972
AMA — Psychiatric Problems of Children; by Hahnemann; 2 hrs. per day; 1 day per week; 18 weeks; 36 hrs. AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Edu. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; October 7, 1971 - February 17, 1972
AMA — Medical Hypnosis; at The Institute of Pa. Hosp.; by The Institute, PMS and PAGP; 4 hrs. per day; 1 day per week; 20 weeks; 80 hrs. AAGP credit requested; fee=$150. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; October 13, 1971 - May 17, 1972
AMA — Seminars in Psychotherapy: Short-term, Crisis & Supportive Therapies; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks per seminar; AAGP credit requested; fee=$150 for 30 weeks, $75 for 10 weeks. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; December 2, 1971 - April 20, 1972
AMA — New Dimensions in Patient Care; by The Institute of Pa. Hosp., PMS and PAGP; at The Institute; 2 hrs. per day; 1 day per week; 18 weeks; 36 hrs. AAGP credit requested; fee=$100. Contact Sydney E. Pulver, M.D., Dir., The Institute of the Pa. Hosp., 111 N. 49th St. Philadelphia 19139.

Philadelphia; January 10 - March 13, 1972
S/AMA — Behavior Therapy; by the Institute of Pa. Hosp. and U. of Pa.; at Hospital of U. of Pa.; 2 hrs. per day; 1 day per week; 10 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 10 - February 14, 1972
S/AMA — Psychopharmacology; by the Institue of Pa. Hosp. and U. of Pa.; 1½ hrs. per day; 1 day per week; 6 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; January 11 - February 29, 1972
S/AMA — Treating Today's Adolescent; by the Institute of Pa. Hosp. and U. of Pa.; 1½ hrs. per day; 1 day per week; 8 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March 18 - May 27, 1972
S/AMA — Principles and Techniques of Group Psychotherapy; at The Institute of Pa. Hosp.; by U. of Pa. and The Institute; 2 hrs. ea. Saturday; 10 weeks; fee=$100; max. enrollment=15. Contact Peter B. Bloom, M.D., Coordinator of Cont. Educa., The Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Philadelphia; March 22 - May 24, 1972
AMA — Adolescence and the Youth Culture; by Hahnemann; 2 hrs. per day; 1 day per week; 10 weeks; AAGP credit requested; fee=$75. Contact Paul Jay Fink, M.D., Dir. of Educ. & Training, Dept. of Mental Health Sciences, Hahnemann, 230 N. Broad St., Philadelphia 19102.

Philadelphia; March 22-May 24, 1972
S/AMA — Advanced Marital Therapy — Treating Sexual Incompatibility; by the Institute of Pa. Hosp. and U. of Pa.; at Marriage Council of Philadelphia; 2½ hrs. per day; 1 day per week; 10 weeks; fee=$100. Contact Peter B. Bloom, M.D., Coordinator, Cont. Educ. for Psychiatrists, The Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

Sayre; July 27, 1971 — May 8, 1972
Rotating Specialty Seminar/Psychiatry; at Robert Packer Hosp.; 1 hr. per day; 1 day per week; 10 weeks; 10 hrs. AAGP credit approved. Contact Paul C. Royce, M.D., Ph.D., D.M.E., Robert Packer Hosp., Guthrie Square, Sayre 18840.

OTHER COURSES
code

C—Continuous (Consecutive Days)
O—One Day or Less
PG—Postgraduate Traineeship
M—Multiple Sites (Circuit)

ALLERGY

February 7 - March 13, 1971; Philadelphia (repeat May 1 - June 23, 1972)
PG/AMA — Clinical Immunology Tutorial Course; at Hahnemann; 7-8 hrs. per day; 40 days; fee = $500. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

ARTHRITIS & RHEUMATISM

Continuous; Philadelphia
PG/AMA — Rheumatology Tutorial Course; at Hahnemann; 6-7 hrs. per day; 2 days per week; 4 weeks; fee = $150. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CARDIOVASCULAR DISEASE

Continuous (2 or 3 weeks in each sub-section); Philadelphia
PG/AMA — Tutorial Courses; Fluid and Electrolyte Metabolism; Hypertension (Clinical & Laboratory); Dialysis; Cardio-Hemodynamics; Cardiac Care Unit; Electrophysiology; Vector-Electrocardiography and Cardiovascular Pharmacology; Atherosclerosis and Lipid Metabolism; Phono-Echo; Clinical Cardiology and Cardiovascular Surgery; at Hahnemann; 6, 7, 8, or 9 hrs. per day; 10 or 15 days; fee = $300 ea. subsection. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

March 16-17, 1972; Philadelphia
C— Cardiopulmonary Resuscitation Instructors' Training Course; at Emergency Care Research Institute; by Pa. Heart Assoc. and Heart Assoc. of Southeastern Pa.; 7 hrs. ea. day; fee=$40. Contact Emergency Care Research Inst., 913 Walnut St., Philadelphia 19107.

March 21-22, 1972; Pittsburgh (repeat starting June 6, 1972)
C— Cardiopulmonary Resuscitation Instructors' Training Course; at Pitt; by Pa. Heart Assoc. and Western Pa. Heart Assoc.; 7 hrs. per day; 2 days; fee=$40. Contact Div. of Cont. Educ., Pitt, 1022-H Scaife Hall, Pittsburgh 15213.

December 13-17, 1971; Philadelphia
C/AMA — High Blood Pressure, 1971 (26th Hahnemann Symposium); by Hahnemann; at Sheraton Hotel; 7 hrs. per day; 5 days; 35 hrs. AAGP credit

approved; fee = $175. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

March 13-15, 1972; Philadelphia
C/AMA — Non-Invasive Technique in Evaluation of Cardiac Function; at U. of Pa.; by American Heart Assoc., Pa. Heart Assoc. and Heart Assoc. of Southeastern Pa.; fee (for Fellows) — $60. Contact Miss Carole Mintz, Dept. of Med. Ed., American Heart Assoc., 44 E. 23rd St., New York City 10010.

April 10-21, 1972; Philadelphia
C/AMA — Core Curriculum-Fundamentals and Applied Clinical Cardiology Seminar; by Hahnemann; 7 hrs. per day; 12 days; 84 hrs. AAGP credit requested; fee = $300. Contact Frederick K Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

July 17-19, 1972, Philadelphia
C/AMA — Bedside Diagnosis of Heart Disease; by Hahnemann; 7 hrs. per day; 3 days; 21 hrs. AAGP credit requested; fee = $125. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CHEST DISEASES

Continuous (4 weeks in each sub-section); Philadelphia
PG/AMA — Tutorial Courses: Clinical Pulmonary Disease; Inhalation Therapy; Pulmonary Physiology; Respiratory Intensive Care; at Hahnemann; 7, 8, or 9 hrs. per day; 20 days; fee =$350. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

December 6-17, 1971; Philadelphia (Hahnemann)
March 14-25, 1972; Allentown Hospital
M/AMA — A Workshop in Respiratory Intensive Care; by Greater Delaware Valley RMP; 2 weeks; 5 days ea. week; 70 hrs. AAGP credit approved. Contact F. R. Johnston, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

February 28-March 10, 1972; Philadelphia
PG — Bronchoesophagology; at Temple; $350 fee; planned for chest physicians, thoracic surgeons, anesthesiologists and gastroenterologists. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

May 3-6, 1972; Philadelphia
C/AMA — Pulmonary Care in the Seventies (27th Hahnemann Symposium); by Hahnemann; at Marriott Motor Hotel; 5-6 hrs. per day; 4 days; 25 hrs. AAGP credit approved; fee = $175. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

May 25-27, 1971; Pittsburgh
AMA/C — Critical Care (Acute) Medicine; by Pitt and American College of Chest Physicians; at Pitt. Contact Esther BarCarmi, Registrar, Continuing Education Programs, American Coll. of Chest Physicians, 112 E. Chestnut St., Chicago, Ill 60611.

EMERGENCY MEDICINE

February 7-18, 1972; Philadelphia (repeat May 2-13, 1972)
PG/AMA — Emergency Room Tutorial Course; by Hahnemann; 8 hrs. ea. day; 10 days; fee=$400. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

April 11, 1972; Hershey
O/AMA — Emergency Room Techniques; by PMS and Pa. Trauma Committee of ACS; at Hershey; 6 hrs.; min. enrollment=50. Contact PMS (Emergency Med. Service), 20 Erford Rd., Lemoyne 17043.

ENDOCRINOLOGY

March 6-31, 1972; Philadelphia
PG/AMA — Endocrinology and Metabolism Tutorial Courses; at Hahnemann, 7-8 hrs. per day; 20 days; fee=$350. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

GASTROENTEROLOGY

April 15, 1972; Hershey
O — Seminar on Gastroenterology; by PMS and Pa. Osteopathic Assoc.; at M.S. Hershey; 6 hrs. AAGP and ACGP credit requested; fee=$100; min. enrollment=20. Contact PMS (PMS-POA Seminar), 20 Erford Rd., Lemoyne 17043.

GENERAL MEDICINE

Continuous; Philadelphia
PG/AMA — Tutorial Courses: Basic General Medicine (7-8 hrs. per day; 60 days; fee=$700); Critical Care Medicine (8-9 hrs. per day; 10 days; fee=$300) at Hahnemann. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

As Requested, 1971; Philadelphia
PG — Acute Care Medicine Fellowship (retraining program for women physicians); by M.C. of Pa.; 6 hrs. per day; 1 yr. duration. Contact Ethel Weinberg, M.D., Assoc. Dean, MCP, 3300 Henry Ave., Philadelphia 19129.

As Arranged; Philadelphia
PG — Preceptorship for Practicing Physicians; at M.C.P.; may be arranged as 1 day per week in 16-week block @ $200-$300, 2 weeks @ $250, 3 weeks @ $375 or 1 month @ $500; programs available in Int. Med., Ob. & Gyn., Pediatrics, Psychiatry, Radiology and Surgery. Contact Gerald H. Escovitz, M.D., Dir. Regional Medical Program Activities, M.C.P., 3300 Henry Ave., Philadelphia 19129.

Third Wed. ea. mo.; Aliquippa-Rochester Hospitals (rotation)
Fourth Thurs. ea. mo.; Altoona Hospital
First Tues. ea. mo.; Greensburg (Westmoreland Hosp.)
First Thurs. ea. mo.; Johnstown (Conemaugh Valley Mem. Hosp.)
Second Tues. ea. mo.; Natrona Heights (Allegheny Valley Hosp.)
Last Mon. ea. mo.; Uniontown Hospital
First Wed. ea. mo.; Washington Hospital
M — Diagnosis and Management of Hypertension; by Western Pa. Regional Medical Program and Pitt; AAGP credit applied for. Contact Alvin P. Shapiro, M.D., Project Dir., 501 Flannery Bldg., 3530 Forbes Ave., Pittsubrgh 15213.

January, 1972; Allentown
January, 1972; King of Prussia

M— The Physician and Addictive Disease; by PMS, PAGP, Pa. Dept. of Health and Pa. Dept. of Welfare; 8 hrs. AAGP credit requested; min. enrollment=10, fee=$10. Contact PMS, 20 Erford Rd., Lemoyne 17043.

December 13-17, 1971; Philadelphia
C/AMA — High Blood Pressure - 1971; by Hahnemann; at Sheraton Hotel; 8 hrs. ea. day; 4½ days; 35 hrs. AAGP credit requested; $125 fee. Contact Mrs. Sage Cordell, Asst. Dir., Cont. Educ., 230 N. Broad St., Philadelphia 19102.

May 4-6, 1972; St. Davids
C — Annual Main Line Conference of Bryn Mawr Hosp.; at Treadway Inn; 2½ days; 15 hrs. AAGP credit approved; fee=$35. Contact Theodore J. Berry, M.D., DME, Bryn Mawr Hosp., Bryn Mawr 19010.

INTERNAL MEDICINE

January 3-7, 1972; Philadelphia
C/AMA — Workshops in the Physiology, Pathophysiology and Diagnosis of Disorders of Electrolyte and Acid-Base Metabolism; by Amer. Coll. of Physicians; at Hospital of the U. of Pa.; Fee: Members and F.A.C.P. = $80, non-members =$125, candidate members and ACP Latin American Fellows = $40. Contact Registrar, Postgraduate Courses, Amer. Coll. of Physicians, 4200 Pine St., Philadelphia 19104.

March 20-24, 1972; Philadelphia
C/AMA — Specifically Treatable Diseases (Emphasizing Pathophysiology and Early Clinical Findings); by Amer. Coll. of Physicians; at Pennsylvania Hosp. and U. of Pa.; Fee: Members and F.A.C.P.=$80, non-members=$125, candidate members and ACP Latin American Fellows=$40. Contact Registrar, Postgraduate Courses, Amer. Coll. of Physicians, 4200 Pine St., Philadelphia 19104.

MALIGNANT DISEASE

February 7 - March 3, 1972; Philadelphia (repeat April 3-28, 1972)
PG/AMA — Hematology and Medical Oncology Tutorial Course; at Hahnemann; 8-9 hrs. per day; 20 days; fee=$400. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

NEPHROLOGY

June 5-7, 1972; Philadelphia
C/AMA — Nephrology for the Practicing Physician; by Hahnemann; at Holiday Inn; 7 hrs. ea. day; 3 days; 21 hrs. AAGP credit requested; $125 fee. Contact Mrs. Sage Cordell, Asst. Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

NEUROLOGY

Continuous (12 weeks in each sub-section); Philadelphia
PG/AMA— Tutorial Courses: Clinical Neurophysiology (2 hrs. per day; 1 day per week; fee=$250); Neuropathology; Adult Neurology; Pediatric Neurology (5-6 hrs. per day; 60 days; fee=$1,000); at Hahnemann. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

PEDIATRICS

April 13, 1972; Hershey
O — Maternal and Child Health Institute; by PMS and Pa. Dept. of Health; at M.S. Hershey; 7 hrs. AAGP credit requested; min. enrollment=100, fee=$15. Contact PMS (Matern. Health), 20 Erford Rd., Lemoyne 17043.

May 9-12, 1972; Philadelphia
C — Twenty-first Pediatric Postgraduate Seminar; by Temple; at St. Christopher's Hosp. for Children; 6 hrs. ea. day; 24 hrs. AAGP credit requested; $100 fee. Contact John B. Bartram, M.D., St. Christopher's Hosp. for Children, 2600 N. Lawrence St., Philadelphia 19133.

PSYCHIATRY

December 6-10, 1971; Philadelphia
C — Drug Education Workshop for Mental Health Staffs; by Eastern Pa. Psychiatric Institute; 9 to 5 each day; one week; no fee. Contact Mrs. Eva Peeples, Adm. Asst., E.P.P.I., Henry Ave. and Abbottsford Rd., Philadelphia 19129.

December 13 - 17, 1971; Philadelphia
C—Drug Education Workshop for Health and Mental Health Staff Teams; one week residential; at Krisheim Study Center; by Eastern Pennsylvania Psychiatric Institute; fee=$40 (includes room and board). Contact Mrs. Eva Peeples, Adm. Asst., E.P.P.I., Henry Ave., and Abbottsford Rd., Philadelphia 19129.

RADIOLOGY

Continuous; Philadelphia
PG/AMA — Cardiac Radiology; at Hahnemann; 8 hrs. per day; 5 days per week; 3 weeks; fee = $300. Contact Frederick K. Heath, M.D., Dir., Cont. Educ., Hahnemann, 230 N. Broad St., Philadelphia 19102.

SURGERY

January 23-29, 1972; Pittsburgh
C — Concepts of Soft Tissue Surgery; at Mercy Hospital; by Amer. Academy of Facial Plastic and Reconstructive Surgery, Inc.; fee=$400 (special rates for residents and military personnel). Contact John T. Dickinson, M.D., D.Sc., G-2 M.D. Bldg., 1501 Locust St., Pittsburgh 15219.

PHYSICIANS WANTED

Wanted — Family physicians, internist, pediatrician, and orthopedist for solo but medically congenial practice in 128 bed JCAH accredited hospital in well-located southern Indiana city. Contact: Maury Gray, administrator, Dunn Memorial Hospital, Bedford, Indiana 47421.

Coatesville — Internist or General Practitioner needed for appointment on the Medical Infirm Section on Medical Services in accredited VAH — 38 miles west of Philadelphia. Affiliated with Thomas Jefferson University School of Medicine. Licesne any state. Salary range $17,761 through $29,907 commensurate with training and experience. Excellent fringe benefits. Contact chief of staff, VAH, Coatesville, Pa. 19320 — Equal Opportunity Employer.

General or Family Practitioners needed — to locate in Northeastern Pa. Excellent opportunity to join a five-man group practicing comprehensive medicine. Located in Endless Mountains, hunting, fishing, boating and skiing. Three hours from metropolitan areas. Affiliated with private hospital, fully accredited, and modern extended care facility. Contact Eudora S. Bennett, R.N., Administrator, Montrose General Hospital, Montrose, Pa. 18801. Telephone collect: 1-(717)-278-3801.

Internist and G.P., M.D., or D.O. for immediate opening. Central Pennsylvania, Huntingdon County. For immediate opening, forming new group, to associate with established M.D.; affiliated with two hospitals at Huntingdon or Tyrone. Beautiful area of Pennsylvania. All sports, pleasurable recreation for yourself and family. Located one-half hour from Penn State University and Raystown Dam. Salary or partnership available. Write or call collect: Donald C. Malcolm, M.D., Juniata Valley Medical Center, Inc., Alexandria, Pa. 16611. Tel: (814) 669-444.

General Practitioner — Excellent growth opportunity in community with 112-bed hospital. Field wide open for extensive practice. Ideal professional and social opportunities. Contact: John H. Vastine Foundation, 100 West Independence St., Shamokin, Pa. 17872.

Radiologist — Certified or eligible. To join two men. Community Hospital. Diagnosis and nuclear medicine experience. Philadelphia. Write Box #597, Pennsylvania Medicine, Lemoyne, Pa. 17043.

Family Physician — Join two diplomates of Family Practice, 25 miles from hospitals in Harrisburg (associated with Hershey and Hahnemann Medical Colleges), Lewistown, and Carlisle. All hospital admissions referred. Starting salary $25,000, full partnership in one year. W.H. Magill, M.D., and J.O. Rumbaugh, Jr., M.D., Newport, Pa. 17074.

Pediatrician for pediatric department to develop the pediatric component of a prepaid medical care program. Adequate time to develop full-time academic program. Resume to Department of Pediatrics, 1015 Walnut St., Philadelphia, Pa. 19107. Attention of Dr. Robert L. Brent.

Ophthalmology Partnership — Pennsylvania. Board Certified or eligible ophthalmologist for partnership in established but still growing practice. Beautiful Pennsylvania community convenient to Philadelphia and New York. New hospital underway. Man with family and practice experience preferred. Excellent opportunity for right man. Contact Opthalmology Associates, 106 East State St., Doylestown, Pa. 18901. Tel: (215) 343-2323.

POSITION WANTED

Radiologist, age 42 — Desires position in small city or town; solo or association. Trained in diagnosis, therapy, and isotopes. Available in 6 months. Write Department 596 Pennsylvania Medicine, 20 Erford Rd., Lemoyne, Pa. 17043.

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122nd Annual Session of the House of Delegates Pittsburgh, October 4-6, 1971

The House of Delegates of the Pennsylvania Medical Society convened its 122nd Annual Session at 7:40 p.m., October 4, 1971, in Ballroom No. 1 of the Pittsburgh Hilton with William Y. Rial, M.D., Speaker, presiding. William R. Davison, M.D., Chairman of the Committee on Credentials, reported that a quorum was present. Robert S. Sanford, M.D., Trustee and Councilor from the Seventh District, gave the invocation.

The first meeting, which continued until 9:40 p.m., included the addresses of President William A. Limberger, M.D., and President-Elect George P. Rosemond, M.D.

The second meeting was convened at 8:10 a.m., October 6, 1971, at which time the report of the Reference Committee on Constitution and Bylaws was adopted. Following elections, the reference committee reports on Reports of Standing and Special Committees, Reports of Officers, Public Service, Education and Science, and Medical Service "A" were acted upon. The House recessed at 11:45 a.m., for lunch and balloting, reconvening at 1:00 p.m., at which time it acted on the reference committee reports on Governmental Relations and Medical Service "B".

The House of Delegates approved the recommendation of the Board of Trustees and Councilors that the 1972 annual assessment be $100 for each full dues-paying active member.

The 122nd Session of the House of Delegates adjourned sine die at 1:30 p.m., Wednesday, October 6, 1971.

(Editor's Note: In those cases where the House of Delegates voted against the recommendation of the Reference Committee Report, that action is specifically stated. Support by the House of Delegates for the recommendations of the Reference Committees may be assumed unless opposition is specifically stated.)

The Opening Session of the House, October 4, 1971

The Speaker called the opening session of the 1971 House to order at 7:40 p.m., Monday evening, October 4, 1971, in Ballroom No. 1 of the Pittsburgh Hilton. After hearing a report from William R. Davison, M.D., Chairman of the Credentials Committee, that a quorum was present, Dr. Rial called upon Robert S. Sanford, M.D., to deliver the invocation.

Committee on Rules

G. Winfield Yarnall, M.D., Chairman, presented the following report of the Committee on Rules, which was adopted by the House:

1. Standing Rules of the House of Delegates

Mr. Speaker, we have reviewed the six standing Rules of the House of Delegates as found on Pages 3 and 4 of the *Official Reports Book* and find them acceptable. We note, however, that Items 9 and 10 call for the speeches of the President of the Woman's Auxiliary, the President of the Society and the President-Elect to be given consecutively. We are advised that the Speaker wishes permission of the House to intersperse other business between these speeches.

We RECOMMEND that the Speaker be authorized to seek a more harmonious arrangement of the order of business for the first meeting of the House.

2. Sequence of Nominees on the Ballot

Mr. Speaker, Standing Rule No. 6 directs that the ballots be so prepared as to clearly indicate nominees from the Nominating Committee for the offices of Delegate and Alternate to the AMA. In so doing, we believe that the order in which names are listed takes on added significance. So that there may be a policy regarding the order in which names appear, we *RECOMMEND that all names on the ballot be listed alphabetically with an asterisk denoting those being nominated by the Nominating Committee.*

Necrology Report

The House stood in tribute to receive the following necrology report, presented by Park M. Horton, M.D., Chairman of the Board of Trustees:

"At this time it is customary to ask you to give a moment's thought to our members who may have been with us here a year ago, but, in the past months, have responded to their last roll call. Their names have been memorialized in county medical society bulletins and in Pennsylvania Medicine, the journal of the Pennsylvania Medical Society.

From September 1, 1970, to August 31, 1971, we have lost by death 226 members; 22 not over 50 years of age; 107 between 51 and 70; and 97 in the group aged 71 to over 90. Of these 226 members, 104 were associates, most of whom were 65 years of age or over. The necrology report at the last Annual Session reported the loss of 285 members.

May we rise for this moment in silence and respect to those members who have passed to their eternal reward during the past year."

Report of the Standing Committee on Constitution and Bylaws

R. Robert Tyson, M.D., Chairman, referred to the Report of the Standing Committee on Constitution and Bylaws as published on page 56 of the *Official Reports Book*, and to the proposed amendments to the Constitution and Bylaws contained in the "Official Call" on pages 5-13

of the *Official Reports Book*. These materials were received as official business by the House of Delegates and referred to the Reference Committee on Constitution and Bylaws.

Committees of the 1971 House of Delegates

The speaker announced that the following appointments had been made to Committees of the House:

Committee on Credentials
William R. Davison, M.D., Cambria County, Chairman
Stephen I. Dodd, M.D., Mifflin-Juniata County
Harold J. Reinhard, M.D., Warren County
John H. Shugert, M.D., Beaver County
Nicholas Spock, M.D., Northumberland County

Committee on Rules
G. Winfield Yarnall, M.D., Dauphin County, Chairman
Alan B. Adam, M.D., Elk-Cameron County
Gertrude Blumenschein, M.D., Fayette County
Herbert A. Friedman, M.D., Monroe County
Ralph M. Weaver, M.D., Butler County

Tellers
Fred J. Phillips, M.D., Bucks County, Chairman
William C. Long, M.D., Clinton County
David L. Miller, M.D., Clarion County
Roderick R. McLeod, M.D., Armstrong County
Arthur J. Patterson, M.D., Greene County
Richard W. Skinner, M.D., Blair County
Theodore S. Wedde, M.D., Columbia County

Committee on Constitution and Bylaws
R. Robert Tyson, M.D., Philadelphia County, Chairman
William F. Donaldson, Jr., M.D., Allegheny County
Vincent Ricciutti, M.D., Mercer County
Bienvenido V. Simuangco, M.D., Potter County
H. Robert Davis, M.D., Cumberland County

Committee on Education and Science
Malcolm W. Miller, M.D., Philadelphia County, Chairman
Dominick A. Cruciani, Jr., M.D., Lackawanna County
Arthur I. Murphy, Jr., M.D., Allegheny County
Ling G. Wong, M.D., Centre County
Paul Bialas, President, SAMA chapter, Thomas Jefferson University

Committee on Governmental Relations
Robert S. Pressman, M.D., Philadelphia County, Chairman
Armand J. Angulo, M.D., Franklin County
Richard N. McGarvey, M.D., Allegheny County
Thomas P. Petrick, M.D., Westmoreland County
William A. Steinbach, III, M.D., Bradford County

Committee on Medical Service - Section "A"
Robert A. Schein, M.D., Allegheny County, Chairman
William F. Beyer, M.D., Chester County
Paul A. Bowers, M.D., Philadelphia County
Frederick G. Brown, M.D., Montour County
John P. Whiteley, M.D., York County

Committee on Medical Service - Section "B"
Ulysses E. Watson, M.D., Montgomery County, Chairman
Robert Kirkpatrick, M.D., Crawford County
Eugene W. Herron, M.D., Westmoreland County
Donald R. Cooper, M.D., Philadelphia County
Rex A. Pittenger, M.D., Allegheny County

Committee on Public Service
Kenneth Miller, M.D., Allegheny County, Chairman
Frank Belmont, M.D., Perry County
Carol N. Maurer, M.D., Venango County
Margaret Mullins, President, SAMA chapter, Medical College of Pennsylvania
Charles K. Zug, III, M.D., Northampton County

Committee on Reports of Officers
Anthony T. Merski, M.D., Erie County, Chairman
Edward R. Hagopian, M.D., Delaware County
John H. Moyer, III, M.D., Philadelphia County
William T. Musser, M.D., Union County
Ralph J. Stalter, M.D., Allegheny County

Committee on Reports of Standing and Special Committees
James Welsh, M.D., Berks County, Chairman
Russel A. Boykiw, M.D., Clearfield County
Michael Christy, M.D., Luzerne County
David W. Clare, M.D., Allegheny County
Edwin M. Price, M.D., Somerset County

PaMPAC Presentation

William B. West, M.D., Chairman of the PaMPAC Board of Directors, presented an informational report to the House. Dr. West's remarks are attached as Appendix A.

Announcements

Dr. Lovette introduced officers of the Society, members of the Judicial Council, and members of the Board of Trustees and Councilors.

Approval of Proceedings

The proceedings of the 121st Annual Meeting of the Society in Lancaster, October 5-7, 1970, were approved as published in the December 1970 issue of PENNSYLVANIA MEDICINE.

Address of the President

William A. Limberger, M.D., President, presented a

report on his year as President (published in the November 1971 Pennsylvania Medicine). Dr. Limberger's address was referred to reference committees as indicated in Appendix B.

Distinguished Guests

The following distinguished guests were presented to the House: DeWitt E. DeLawater, M.D., president-elect, Medical and Chirurgical Faculty of Maryland; E. Vernon Davis, M.D., president, Medical Society of New Jersey; P. John Robechek, M.D., president, Ohio State Medical Association; Harry S. Weeks, Jr., M.D., president, West Virginia Medical Association; W. Arthur George, D.D.S., president, Pennsylvania Dental Association; Dr. LaRue Lunger, president, Pennsylvania Pharmaceutical Association; the Honorable H. Reginald Belden, president, Pennsylvania Bar Association; Mrs. Agnes E. Smith, president, American Association of Medical Assistants, Pennsylvania Society; and Joseph W. Stella, D.O., president, Pennsylvania Osteopathic Association.

It was noted that an invitation was also extended to Wesley W. Hall, M.D., President of the American Medical Association, to address the House. Due to a prior engagement, Dr. Hall was unable to attend.

An invitation was extended to the Honorable Peter F. Flaherty, Mayor of Pittsburgh, to welcome the delegates to the annual meeting. The mayor said in his letter of regret:

"Unfortunately, my calendar is already full for the week of October 4, and I will not be able to be with you due to previous commitments. However, I would like to take this opportunity to wish you all a very pleasant and very memorable session.

Thank you very much for the kind invitation.

Very truly yours,
Pete Flaherty"

It was announced that an invitation to address the House had been sent to Governor Milton J. Shapp, but that no reply had been received.

Address of the President-Elect

The remarks (published November, 1971, Pennsylvania Medicine) of President-Elect George P. Rosemond, M.D., were referred as indicated in Appendix C.

SAMA Delegates

The following SAMA delegates also were introduced: Zdzislavs J. Wanski, University of Pittsburgh School of Medicine; Henry Mishel, Hahnemann Medical College and Hospital of Philadelphia; Paul A. Bialas, Jefferson Medical College of Thomas Jefferson University; Margaret Mullins, The Medical College of Pennsylvania; and Ralph Gallo, Temple University School of Medicine.

Acceptance of Reports and Resolutions

All material contained in the 1971 *Official Reports Book*, with the exception of Resolution 71-5: "Financial Assistance for Members of the Pennsylvania Medical Society Who Wish to File a Counter Suit" (Withdrawn) was accepted as the official business of the House.

The following supplemental reports were contained in the *Official Reports Book* and became the official business of the House:

(1) Supplemental Report of the Pennsylvania Delegation to the AMA (Referred to the Reference Committee on Reports of Officers - Except as Indicated) Appendix D.

(2) Supplemental Report A of the Board of Trustees & Councilors (Referred to Reports of Officers) Appendix E.

(3) Supplemental Report A of the Council on Medical Service (Referred to Reference Committee on Medical Service A) Appendix F.

(4) Supplemental Report B of the Council on Medical Service (Referred to Reference Committee on Medical Service B) Appendix G (a summary).

The following supplemental reports in the delegate's packets were received as official business of the House:

(1) Supplemental report of the Council on Government Relations (Referred to the Reference Committee on Governmental Relations) Appendix H.

(2) Blue Shield Report (Referred to Reference Committee on Medical Service"A"). Available on request.

(3) Annual Report of the Educational and Scientific Trust (Referred to the Reference Committee on Standing and Special Committees). Also available on request.

(4) The leaflet "Ultimate Gift," available on request.

(5) Letter from Dr. Limberger, dated September 22, 1971, regarding the Department of Public Welfare's Medical Assistance Program and more specifically, Memorandum No. 16. Appendix I.

(6) Supplemental Report B from the Board of Trustees and Councilors (referrals indicated in report which is published as Appendix J).

(7) Statement before the opening session of the House of Delegates by David S. Masland, M.D., Chairman, Finance Committee (Referred to Reports of Officers).

(8) Proposed budget for 1972. Available upon request.

Finance Committee Report

David S. Masland, M.D., Chairman, presented the following report from the Finance Committee of the Board of Trustees and Councilors, which was referred to the Reference Committee on Reports of Officers.

"Last year at this time, I predicted that rising costs and the initiation of programs crucial to the membership and the public would oblige the Finance Committee to recommend a dues increase for 1972. Unfortunately, that prediction has come true. Based on the projected budget for 1972, the Finance Committee and the Board of Trustees have authorized me to recommend a dues increase of $25.

The final recommendation will depend upon action that the House of Delegates takes on Wednesday concerning the reports of reference committees. I will return with a final recommendation near the end of the Session of the House on Wednesday.

A copy of the proposed budget for 1972 as approved by the Board of Trustees has been distributed for your information. In addition to the 1972 figures, it contains the comparative figures of the approved budget for 1971, as well as the actual expenditures incurred for the first eight months of 1971. The 1972 budget is based on current annual assessment of $75 per full dues-paying member. You will note that the budget anticipates a deficit of $121,569. Without reimbursement from the federal government for manage-

ment services to the SVRMP, our projected deficit would exceed $219,000.

Since the rate of reimbursement from the federal government is subject to fluctuation and is dependent upon federal audit and review, we cannot totally rely on receiving the amount noted in our budget. Someday, of course, either the program or the Society's involvement in it will come to an end, either at our initiation or at the government's. In the meantime, the rate of reimbursement from this source is expected to decline.

Projected income and reimbursement remain essentially the same, but expenses continue to climb. The budget projects roughly a 5 percent increase in costs in 1972.

Since 1964 the Society has avoided a dues increase. This was accomplished by prudent expenditure of funds by councils and committees. Last year the Society stayed out of the red because of federal reimbursement for its management of the Susquehanna Valley Regional Medical Program.

During the past 7 years we have experienced a 32.8 percent rate of inflation. Nearly a third of the Society's purchasing power has eroded in the process. During the same time the Society has increased its activities and initiated programs designed to assure quality medical care as well as optimum utilization and distribution of medical services. The Society also constructed a new headquarters building during this period without the need for a special building assessment, a dues increase or a large mortgage. I think you will agree that the membership received an excellent return on that last dues increase.

This year the House of Delegates will give careful study to a comprehensive plan to implement the Pennsylvania Medical Care Foundation—perhaps the most significant program the Society has initiated in a decade. Obviously we cannot afford to curtail such programs as this which are vital to the membership's interest and to the public good.

Other state medical societies of comparable size, activities, and influence have increased their dues an average of 41 percent since 1965. The annual assessment in these states now approximates $105 per member. There are 16 states with dues of $100 or more.

You are aware that the country is in the middle of a wage/price freeze and that the economic guidelines will not permit the kind of dues increase which the Finance Committee and the Board of Trustees will recommend; still we feel compelled to seek the authorization from this House for a dues increase which will balance the projected budget, allowing for continuation of programs approved by this House of Delegates. The actual amount of increase, however, will of course comply with the stipulations, if any, which will be contained in the guidelines.

I repeat my earlier statement that the budget before you is based on the current annual assessment. The Finance Committee is counting on the continued prudent expenditure of funds by the councils and committees and is hopeful that it can hold the line on the deficit at the current level. The Finance Committee plans to note and evaluate for budgetary purposes any new programs which you approve. Please bear in mind that every recommendation for a new or expanded project which you adopt during this meeting of the House of Delegates will cost money to implement. Increased expenses will result in a larger projected deficit for 1972 and may necessitate a recommendation for a larger dues increase.

If there are any questions concerning the budget or the financial condition of the Pennsylvania Medical Society, please attend the hearing of the reference committee on Reports of Officers. Members of the Finance Committee will be available to hear opinions and will attempt to answer any questions which may arise."

The following six resolutions received after September 4, 1971, were accepted as business of the House of Delegates:

RESOLUTION No. 71-11
Subject: Usual and Customary Fees for Commonwealth Program

Introduced by: Robert M. Kerr, M.D. in behalf of the Luzerne County Medical Society

Author: Robert M. Kerr, M.D.

RESOLUTION No. 71-12: State Committee on Quackery, introduced by Frank J. DiLeo, M.D., in behalf of the Lehigh County Medical Society (author - Stephen J. Barrett, M.D.), referred to the Reference Committee on Governmental Relations.

RESOLUTION No. 71-13: Seventy-Two Hour Review Clause—DPW Memorandum, No. 16, introduced by Herbert A. Friedman, M.D., in behalf of the Monroe County Medical Society (author - James C. Fahl, M.D.), referred to the Reference Committee on Medical Service "A".

RESOLUTION No. 71-14: Russell B. Roth, M.D., introduced by John D. Alexander, Jr., M.D., in behalf of the Philadelphia County Medical Society (author - John D. Alexander, Jr., M.D.).

(Secretary's Note: The Chair asked for and received permission to turn the House of Delegates into a Reference Committee of the whole at this point so as to act upon Resolution 71-14 immediately. Such permission was given, whereupon it was moved and seconded that Resolution 71-14 be adopted.)

WHEREAS, Russell B. Roth, M.D. has served his County Medical Society, The Pennsylvania Medical Society, and the American Medical Association with excellence in devotion, skill, and duty beyond any possibility of listing; therefore be it

RESOLVED. That this House of Delegates unanimously supports the plans of the Pennsylvania delegation to the American Medical Association to nominate Dr. Roth and support his candidacy for the position of President-Elect of the American Medical Association in June of 1972.

RESOLUTION No. 71-14 was adopted unanimously.

RESOLUTION No. 71-15: Department of Public Welfare Payments to Hospitals, introduced by John D. Alexander, Jr., M.D., in behalf of the Philadelphia County Medical Society (author - R. Robert Tyson, M.D.), referred to the Reference Committee on Medical Service "A".

RESOLUTION No. 71-16: Shortage of Practicing Physicians, introduced by Ernest L. Abernathy, M.D., in behalf of the Washington County Medical Society (author - Ernest L. Abernathy, M.D.), referred to the Reference Committee on Education and Science.

Remarks of President of Woman's Auxiliary

Mrs. Leroy A. Gehris, President, Woman's Auxiliary to the Pennsylvania Medical Society, addressed the House and her remarks (Appendix K) were referred to the Reference Committee on Standing and Special Committees.

Announcements

Dr. Rial invited all new delegates and alternates to a reception by the Speaker and Vice Speaker immediately following the recess of the House.

Noting the check-out time of 1:00 p.m., the speaker asked if delegates would be interested in moving the starting time of the second session of the House of Delegates up from 9:00 a.m. to 8:00 a.m., Wednesday, October 6, 1971.

Motion: It was moved and seconded that the starting time of the second session of the House of Delegates be advanced to 8:00 a.m. Motion carried.

The opening session of the House was recessed at 9:40 p.m., Monday, October 4, 1971, to the State Dinner Tuesday evening, October 5, at 7:00 p.m.

1971 State Dinner
Invocation

The Invocation was given by Robert S. Sanford, M.D., Trustee from the Seventh Councilor District.

Introduction of Guests

Dr. Limberger introduced the following guests: Dr. and Mrs. William Y. Rial, Speaker, House of Delegates; Dr. and Mrs. Robert S. Sanford, member, Board of Trustees; Mrs. Leroy A. Gehris and Dr. Gehris, retiring President, Woman's Auxiliary to the PMS; Dr. and Mrs. George P. Rosemond, President-Elect; Dr. and Mrs. Park M. Horton, Chairman, Board of Trustees; Dr. and Mrs. J. Finton Speller, Secretary of Health, Pennsylvania; Mrs. Ralph S. Blasiole and Dr. Blasiole, president, Woman's Auxiliary, PMS; and John F. Rineman, executive director and treasurer, PMS.

Dr. and Mrs. DeWitt E. DeLawater, president-elect, Medical and Chirurgical Faculty of Maryland; Dr. and Mrs. E. Vernon Davis, president, Medical Society of New Jersey; Dr. and Mrs. P. John Robechek, president, Ohio State Medical Association; Dr. and Mrs. Harry S. Weeks, Jr., president, West Virginia Medical Association; Dr. and Mrs. W. Arthur George, president, Pennsylvania Dental Association; Mr. and Mrs. LaRue Lunger, president, Pennsylvania Pharmaceutical Association; Mr. and Mrs. H. Reginald Belden, president, Pennsylvania Bar Association; Mrs. Agnes E. Smith and Mr. Smith, president, Pennsylvania Society of the American Association of Medical Assistants; Mrs. Carol Dolack, president-elect, Pennsylvania Society of the American Association of Medical Assistants; and Dr. Joseph W. Stella, president, Pennsylvania Osteopathic Association.

Dr. Limberger introduced the following Past-Presidents: Dr. William A. Barrett and Mrs. Barrett (1969); Dr. William B. West and Mrs. West (1965); Dr. Richard A. Kern (1964); Dr. Wilbur E. Flannery and Mrs. Flannery (1963); Dr. Thomas McCreary and Mrs. McCreary (1960); Dr. Allen W. Cowley and Mrs. Cowley (1959); Dr. Lewis W. Jones (1951); and Dr. Lewis T. Buckman (1941).

Dr. Limberger also introduced Dr. Russell B. Roth, speaker of the AMA House of Delegates, and Mrs. Roth.

Benjamin Rush Awards

Kenneth R. Cooper, M.D., Chairman of the Council on Public Service, presented the individual and group Benjamin Rush Awards for 1971. The individual award was presented to Gustav W. Schukraft, Fleetwood, Berks County, for his outstanding work as a first-aid teacher. The group award went to the Greenville Lions Club of Mercer County for its work in assisting persons with vision defects. Receiving the award for the Greenville Lions Club was Owen W. Lininger, a past president.

Installation and Oath of Office

Park M. Horton, M.D., Chairman of the Board of Trustees, installed George P. Rosemond, M.D., Philadelphia, as the 122nd President of the Pennsylvania Medical Society.

Past President's Medallion

Dr. Horton presented the Past President's Medallion and plaque to William A. Limberger, M.D.

Adjournment

Following entertainment, provided by Nina Little Productions of New York City, the formal portion of the program adjourned at 9:50 p.m. Members and their guests were invited to remain and enjoy dancing until 11:00 p.m. to the music of Joe Schafer and his Orchestra.

Second Session of the House, October 6, 1971

The second session of the House of Delegates was called to order in Ballroom No. 1 of the Pittsburgh Hilton, Wednesday, October 6, 1971, at 8:10 a.m. The Credentials Committee reported that a quorum was present.

Report of the Reference Committee on Constitution and Bylaws

R. Robert Tyson, M.D., Chairman, presented the following report of the Committee, which was adopted by the House:

(Note: Amendments in italics are being added. Amendments enclosed in brackets are being deleted.)

1. *REPORT OF THE STANDING COMMITTEE ON CONSTITUTION AND BYLAWS* (Pages 56-60 of the Official Reports Book)

We have reviewed the report of the Committee on Constitution and Bylaws and all of the items not referred to other reference committees are discussed below.

Mr. Speaker, we recommend the Report of the Committee on Constitution and Bylaws be filed for information.

2. *TECHNICAL CORRECTION OF THE PHRASE "TWO CONSECUTIVE TERMS"*

The PMS staff suggested that there might be uncertainty in the interpretation of the term "two consecutive terms" as it appears in our Constitution and Bylaws. This term has ap-

parently been interpreted to mean that after two consecutive terms the individual is no longer eligible for the same position. This term could also permit the individual concerned to step out for one term or period and then be reappointed to the same position.

Comments at the hearing suggested that perhaps it was best to leave this ambiguity, in that it did not forbid an individual from returning to a position in which he had served two consecutive terms after a layover, but it did convey the idea to those making appointments that it was time to look for a new person.

We concur in the expressed opinions. Mr. Speaker, we RECOMMEND that no changes be made to more specifically define the statement "two consecutive terms."

3. *RESTRUCTURING OF THE MEDICAL DEFENSE FUND* (Pages 11-12 and page 60 of the Official Reports Book)

The Board of Trustees has recommended that the Medical Defense Fund be restructured since its original function is being replaced by the Pennsylvania Medical Society-sponsored Medical Liability Insurance Program. The monies may not be used for other purposes of the Society until the Statute of Limitations make unlikely any further demand on the funds. The suggested changes as they appear on pages 11 and 12 of your Official Reports Book would phase out the Medical Defense Fund. The Board of Trustees would be permitted to financially support medical-legal causes that would significantly affect the Society or a large number of members of the Society. The testimony we heard was in favor of these changes.

Mr. Speaker, we RECOMMEND the adoption of the Bylaws' amendments as set forth in the Official Reports.

4. *IDENTIFICATION OF REFERENCE COMMITTEES* (Supplemental Report B of the Board of Trustees)

The recommendation of the Board of Trustees, originating from the Speaker of the House of Delegates, as indicated in Supplemental Report B of the Board of Trustees, requests that the Speaker of the House be given greater latitude in designating the names and functions of the reference committees of the House of Delegates. This would eliminate all of the previously specified reference committees in Chapter III, Section 9, of the Bylaws except for the Committee on Constitution and Bylaws. We heard no objection to this thought which should effectively streamline the functioning of the House of Delegates and we heard considerable support for this proposal.

Mr. Speaker, we RECOMMEND the adoption of the Bylaws' amendments as they appear in Supplemental Report B of the Board of Trustees (Appendix J).

5. *AMENDED RESOLUTION 70-1: EXPANDED MEMBERSHIP OF THE JUDICIAL COUNCIL* (Pages 5 and 6 and pages 56 and 57 of the Official Reports Book)

Resolution 70-1, in its original form, was a recommendation to considerably expand the number of members of the Judicial Council as well as to change the qualifications necessary for membership. The Reference Committee on Constitution and Bylaws of the 1970 House of Delegates amended this resolution by having such resolution referred to the Standing Committee on Constitution and Bylaws for the purpose of bringing to the House of Delegates at the 1971 annual meeting an appropriate recommendation for the members of this House.

The Standing Committee on Constitution and Bylaws, having solicited and received opinions from appropriate bodies of the Pennsylvania Medical Society, made the following recommendations:

(1) The current five-year term on the Judicial Council with a maximum of two consecutive terms should be reduced to a maximum of three, three-year terms. It is hoped that the shorter term (three years) will be acceptable to younger members and mitigate the fact that they must exclude themselves from virtually all other Society activity while serving on the council. At the same time it allows a man who chooses to serve to remain for a significant period of time.

(2) The Secretary of the Society, who is also secretary to the Judicial Council, should be made a voting alternate in the event that one of the regular members is absent. Thus, without increasing expenses, the Society has moved to guarantee that the greatest number of votes possible will be cast on any given case. The committee does not believe that a court of 7 or 9 would ipso facto render better decisions than a court of 5. Contrarily, a large council would be more unwieldy and more expensive.

(3) The current qualifications for service on the Judicial Council should be liberalized in the area of membership in the House of Delegates. The requirement of ten (10) years of service in the House is too restrictive and should be reduced to five (5).

Testimony at the reference committee hearing was generally in favor of the recommended changes. However, it was pointed out that the Secretary, who would become a potential voting member of the Judicial Council, in the absence of a member of the Judicial Council, was a person who might be politically active and, therefore, might not in this respect meet the general prerequisites for membership on the Judicial Council. We recognize that this is a slight alteration in principle. Since there was little objection to this proposal we feel that it should be approved.

Mr. Speaker, we RECOMMEND approval of the changes in the Constitution as listed on pages 5 and 6 of the Official Reports.

6. *CONTINUING EDUCATION MEMBERSHIP REQUIREMENT* (Pages 7 and 8 and page 58 of the Official Reports Book and Address of the President-Elect)

The 1970 House of Delegates approved the concept of requiring continuing education as a membership requirement, and recommended that the Bylaws be amended to effectuate this requirement for membership effective July 1, 1972. This would coincide with the beginning of a three-year qualifying period established for the AMA Physician Recognition Award. All members should meet the requirement by July 1, 1975. We heard enthusiastic testimony for this proposal at the reference committee hearing.

Mr. Speaker, we RECOMMEND that the Bylaws' changes as they appear on pages 7 and 8 of the Official Reports Book be approved.

7. *INCREASED SIZE OF AND CHANGE IN THE PROCEDURE OF THE COMMITTEE TO NOMINATE DELEGATES AND ALTERNATES TO THE AMA* (Pages 6 and 7 of the Official Reports Book)

The 1970 House of Delegates recommended extensive changes in the Committee to Nominate Delegates and Alternates to the AMA. These changes would add one member from each councilor district to the three members of the present committee, making a total of 15 members. Further, a contest was mandated.

The Standing Committee on Constitution and Bylaws, having received upon its request opinions from a wide variety of members of the Pennsylvania Medical Society and after having reviewed procedures utilized by other large state medical societies, came to the conclusion that there was a better way of accomplishing and maintaining our purpose of an active, functional and respected AMA Delegation. These changes are summarized on page 57 of the Official Reports.

We heard considerable debate at the reference committee hearing concerning this subject. We came to the conclusion that there is no perfect method of accomplishing our purpose that is totally democratic. We feel that the alternative suggestion described by the Standing Committee on Constitution and Bylaws is the most satisfactory solution at this time. This was also the sense of the reference committee hearing.

Mr. Speaker, we recommend the adoption of the Bylaws' changes on pages 6 and 7 as they appear under Item III, Alternate Amendments to Increase the Size and Composition of the Committee to Nominate Delegates and Alternates to the AMA as proposed by the Standing Committee on Constitution and Bylaws.

8. *RESOLUTION 71-4: AFFILIATE MEMBERSHIP* (Pages 134 and 135 of the Official Reports Book)

Introduced by: David S. Cristol, M.D.,
in behalf of the
Board of Directors of the
Philadelphia County Medical Society

Author: David S. Cristol, M.D.

WHEREAS, There are many physicians who have left Philadelphia and the State of Pennsylvania to practice in other parts of the country, and

WHEREAS, Many of these physicians wish to retain medical organization ties with Philadelphia County and the Pennsylvania Medical Society; therefore be it

RESOLVED, That the Bylaws Committee of the Pennsylvania Medical Society be asked to seek an amendment to the State Society Bylaws to allow members of the Pennsylvania Medical Society who move out of the Commonwealth of Pennsylvania to retain membership in their former county society and the Pennsylvania Medical Society as Affiliate Members.

Resolution 71-4, as it appears on pages 134 and 135 of the Official Reports Book requests a Bylaws' change to allow members of the Pennsylvania Medical Society who move out of the Commonwealth of Pennsylvania to be able to retain membership in their county society and the Pennsylvania Medical Society as an affiliate member. Testimony supported this concept. However, concern was expressed as to how this might affect various insurance programs maintained by the Pennsylvania Medical Society and the component societies. We concur with all of the thoughts expressed.

Mr. Speaker, we RECOMMEND referral of this resolution to the Standing Committee on Constitution and Bylaws for study and report back to the 1972 House of Delegates.

9. *REDUCTION IN THE SIZE OF THE COMMITTEE ON OBJECTIVES* (Page 7 and pages 57 and 58 of the Official Reports Book)

The 1970 House of Delegates referred to the Standing Committee on Constitution and Bylaws a recommendation that the Committee on Objectives be reduced in size. The Standing Committee's report concerning this subject appears on pages 57 and 58 of the Official Reports Book. It recommended a committee composed of seven members, four of whom would be appointed from the House of Delegates by the Speaker and three from the Board of Trustees by the Chairman of the Board. There was considerable discussion in the hearing concerning the composition and function of this committee. It was the concensus that this group should be a "think tank," that the results of such a committee's deliberations would be very difficult to measure because of the long-term objectives of their thoughts. There was considerable support of the thought that this committee should represent a cross-section of the Society, including young members. The idea that some members of this committee might not be members of the Pennsylvania Medical Society was even suggested. There was some concern about communications with the Board of Trustees and the House of Delegates. However, it was felt that the presence of the President as an ex-officio member and the usual attendance of the President-Elect would answer the problem of communication to the Board of Trustees and that an annual report to this House of Delegates would be in order.

The suggestion, as set forth by the standing committee, of having three members of the Board as members of this committee, did not seem warranted in view of the attendance by the President and President-Elect, nor did the standing committee's proposal that the Speaker of the House appoint only delegates to this committee.

Mr. Speaker, we RECOMMEND a second alternate revision as follows:

Second Alternate Revision of the
Committee on Objectives
Bylaws
Chapter XIV - Committees, Administrative
Councils and Commissions

Section 2 - Standing Committees.

(g) Committee on Objectives. The Committee on Objectives shall consist of seven members, four of whom shall be appointed by the Speaker and three of whom shall be appointed by the President. When this amended paragraph becomes effective, the President shall appoint three members, one for a term of one year, one for a term of two

years, one for a term of three years, and thereafter annually the President shall appoint one member to this committee for a term of three years; and the Speaker shall appoint four members, one for a term of one year, one for a term of two years, one for a term of three years, and one for a term of four years, and thereafter annually shall appoint one member for a term of four years. Among the appointees from the Speaker shall be included one member who is either a member of SAMA, an Intern, or a Resident. The Committee on Objectives shall report to the Board of Trustees and shall submit annually a written report to the House of Delegates. This committee shall select its own chairman and vice-chairman. It shall be the duty of the committee to recommend objectives to the Board of Trustees and to review annually these objectives and recommend any desirable changes.

10. *TECHNICAL CORRECTIONS* (Pages 9 and 10 and pages 58, 59 and 60 of the Official Reports Book)

It was brought to the attention of the reference committee by the Standing Committee on Constitution and Bylaws that certain technical corrections needed to be made. They are listed on pages 58, 59 and 60 of the Official Reports. No objection was voiced at the reference committee hearing.

Mr. Speaker, we recommend adoption of the technical corrections as set forth in the Official Reports on pages 58, 59 and 60, entitled "Constitution Article XI— Funds," "Constitution— Article IV— Section 6 Interns and Residents," "Bylaws— Chapter XIV— Committees, Administrative Councils and Commissions," and "Change in Name of 'Advisory Committee to the Executive Director' to 'Executive Committee'."

11. *JUDICIAL COUNCIL APPEALS* (Pages 8 and 9, page 58 and page 100 of the Official Reports Book)

The resolution approved by the 1970 House of Delegates requesting an extension of the appeal period from thirty to sixty days was acted upon by the Standing Committee on Constitution and Bylaws as reported on page 58 of the Official Reports Book. A resolution was submitted by your delegation to the American Medical Association concerning the extension of time for filing a notice of appeal. However, the Reference Committee on Constitution and Bylaws of the AMA recommended rejection of this resolution, as indicated on page 100 of the Official Reports Book. This was approved by the House of Delegates of the AMA.

Mr. Speaker, we RECOMMEND that, in view of the position taken by the American Medical Association, the proposed amendment to Chapter XIII, Section 7 of the Bylaws, as set forth on page 9, be rejected.

Mr. Speaker, we RECOMMEND that the proposed amendments to Chapter XIII, Sections 4 and 5 of the Bylaws, as set forth on page 9, be approved.

12. *GRADUATED ASSESSMENT* (Page 59 of the Official Reports Book)

The idea of using all possible means to attract members to the Pennsylvania Medical Society and its component societies was considered by the standing committee and the results of such discussions are reported on page 59 of the Official Reports Book. Additional information concerning the methods of solving this problem by other large states was available to the reference committee. We found that several large states are offering a reduction in dues for new members starting in practice for their first and sometimes second years of practice. We discovered that one national society has a graduated assessment based on income. Although there was no great enthusiasm for using any one specific method to attract members, the concept of a reduction in dues which, if passed by the Pennsylvania Medical Society would also be honored by the American Medical Association seemed acceptable.

Mr. Speaker, we RECOMMEND that the concept of a dues reduction in the first years of a physician's practice be referred to the Standing Committee on Constitution and Bylaws for study and report to the 1972 House of Delegates.

13. *ADDRESS OF THE PRESIDENT-ELECT*

Dr. Rosemond introduced the concept that we should admit third and fourth year medical students to active membership in our Society, in his speech before this House Monday night. This thought stimulated considerable debate among those members attending the reference committee hearing. The initial reaction was a negative one. However, as the discussion continued, the beneficial aspects of this recommendation seemed to outweigh the problems that might be caused by this recommendation. Several members of the Society in the course of discussion changed their opinions and supported the concept of admission of third and fourth year medical students. We believe that the concept should be supported, but we also believe that it is going to take considerable study and deliberation to arrive at a suitable method of accomplishing such purpose.

Mr. Speaker, we RECOMMEND the approval of the concept of admission of third and fourth year medical students to this Society and FURTHER RECOMMEND that this recommendation be referred to the Standing Committee on Constitution and Bylaws for study and report to the 1972 House of Delegates.

Committee to Nominate Delegates and Alternates to the American Medical Association

John B. Montgomery, M.D., Chairman, presented the following report of the Committee:

The Committee to Nominate Delegates and Alternates to the American Medical Association has reviewed the composition of the Delegation. The Committee was informed that as of December 31, 1970, the Pennsylvania Medical Society had 10,824 active members of the American Medical Association and was thus entitled to eleven delegates— a loss of one delegate.

The Committee noted that Dr. Thomas W. McCreary, Sr., of Beaver County, resigned from the delegation after serving as an alternate delegate for eight years and a delegate for fifteen years and feels that the Society is indeed indebted to Dr. McCreary for his yeoman service on behalf of Pennsylvania at the AMA level. The Committee also received word that Dr. Samuel B. Hadden, Philadelphia, and Dr. Wendell B. Gordon, Pittsburgh, did not wish to be renominated this year. The delegation is losing invaluable services with the retirement of these physicians. Dr. Hadden served as a delegate for fourteen years and Dr. Gordon served as an alternate for ten years and a delegate for eight years.

It is the opinion of the Committee that new delegates should be nominated from the list of alternate delegates since the Committee was informed that most alternates attend AMA meetings and are, therefore, versed in the activities of the delegation.

Accordingly, the Committee makes the following nominations for two-year terms commencing January 1, 1972, for delegates to succeed themselves:

John B. Lovette, M.D., Cambria County
Malcolm W. Miller, M.D., Philadelphia County
Russell B. Roth, M.D., Erie County

As new delegates, the Committee nominates former alternate delegates:

Paul S. Friedman, M.D., Philadelphia County
Matthew Marshall, Jr., M.D., Allegheny County

The Committee, in its discussion, noted that there has been some feeling in the House of Delegates that the House should have some choice in the selection of the delegation and the Committee believes that such choice should come in the selection of alternate delegates since, as we have indicated previously, this is the grooming area for advancement to the delegation. Noting there are *five* positions open, the Committee makes the following nominations for two-year terms commencing January 1, 1972 for alternate delegates:

Robert F. Beckley, M.D., Clinton County
Robert J. Carroll, M.D., Allegheny County
Wilbur E. Flannery, M.D., Lawrence County
John Helwig, Jr., M.D., Philadelphia County
William J. Kelly, M.D., Allegheny County
David S. Masland, M.D., Cumberland County
Robert S. Sanford, M.D., Tioga County

The 1970 House of Delegates approved a recommendation that the report of this Committee contain a summary of the activities of each member of the delegation whose term has expired; including his age, length of service on the delegation, and his activities on the delegation in the past year. A similar report is to be made on alternate delegates. The recommendation also indicated that there should be a summary on activities of new nominees, including age. Accordingly, the Committee has attached this report as Appendix A.

(Editor's Note: This material appears in the Proceedings as Appendix L.)

The Vice-Speaker read the following two letters dated August 27, 1971 from Samuel B. Hadden, M.D. to the House:

William Rial, M.D.
111 Dartmouth Avenue
Swarthmore, Pennsylvania 19081

Dear Bill:

I regret that I will not be able to attend the meeting of the Pennsylvania Medical Society in October because I will be at a meeting in Dublin, Ireland.

I sincerely hope that you will make it clear to the delegates that I do not wish to stand as a candidate for election as a Delegate to the American Medical Association. I would appreciate your reading to them the enclosed message.

With best wishes, I remain

Sincerely yours,

Samuel B. Hadden, M.D.

Fellow Delegates to the Pennsylvania Medical Society:

One of the greatest privileges of my life has been to represent the Pennsylvania Medical Society in the House of Delegates of the American Medical Association. The time has come when I feel I should be replaced by a younger man and I assure you that I do believe that Pennsylvania has never been represented by a finer group than the present Delegates and Alternates.

I regret that I cannot be with you but I have long looked forward to attending the meeting of the International Congress on Alcohol and Drug Addiction in Dublin, Ireland, where I will be during your deliberations.

With best wishes and deep appreciation of the privilege of being your Delegate to the A.M.A., I remain

Sincerely yours,

Samuel B. Hadden, M.D.

Elections

Elections were held Wednesday, October 6, 1971. The following officers were elected:

President-Elect: Park M. Horton, M.D., Susquehanna County; First Vice President: Charles K. Rose, Jr., M.D., Lehigh County; Second Vice President: Charles A. Bikle. M.D., Franklin County; Third Vice President: Edward T. Lis, M.D., York County; Fourth Vice President: Carmela F. DeRivas, M.D., Montgomery County; Secretary: Raymond C. Grandon, M.D., Dauphin County; Speaker, House of Delegates: William Y. Rial, M.D., Delaware County; Vice Speaker, House of Delegates: John B. Lovette, M.D., Cambria County.

Park M. Horton, M.D., submitted his resignation as Trustee from the Twelfth District. Additional officers elected: Trustee, Second District: Leroy A. Gehris, M.D., Berks County; Trustee, Eighth District: David J. Keck, M.D., Erie County; Eleventh District: William C. Ryan, M.D., Somerset County; Trustee, Twelfth District: Orlo G. McCoy, M.D., Bradford County.

The following were elected as delegates to the American Medical Association for a term of two years (from January 1, 1972 to December 31, 1973): John B. Lovette, M.D., Cambria County; Malcolm W. Miller, M.D., Philadelphia County; Russell B. Roth, M.D., Erie County; Paul S. Friedman, M.D., Philadelphia County; Matthew Marshall, Jr., M.D., Allegheny County.

The following were elected as alternate delegates to the American Medical Association for a term of two years (from January 1, 1972 to December 31, 1973): Robert F. Beckley, M.D., Clinton County; Wilbur E. Flannery, M.D., Lawrence County; John Helwig, Jr., M.D., Philadelphia County; William J. Kelly, M.D., Allegheny County; David S. Masland, M.D., Cumberland County.

The following were elected to the revised Committee to

Nominate Delegates and Alternates to the American Medical Association: Edgar W. Meiser, M.D., Lancaster County; John B. Montgomery, M.D., Philadelphia County; Fred C. Brady, M.D., Allegheny County; John L. Steigerwalt, M.D., Montgomery County; and Donald E. Harrop, M.D., Chester County.

(Secretary's Note: The House agreed that the terms of office for the members of the Committee to Nominate Delegates and Alternates to the AMA would be chosen by the Committee members at their first meeting, at which time they would pull lots. Subsequently, terms of office will be fixed by the Bylaws.)

Lewis T. Buckman, M.D., Luzerne County, was re-elected to a three-year term on the Judicial Council.

The following district censors were elected for a one-year term:

Adams, James H. Allison; Allegheny, Robert A. Schein; Armstrong, Arthur R. Wilson; Beaver, Herman Bush; Bedford, William E. Palin; Berks, Eugene Mendelsohn; Blair, John W. Hurst; Bradford, Willis A. Redding; Bucks, Stanley F. Peters; Butler, Robert C. McCorry; Cambria, Warren F. White; Carbon, James Farr; Centre, H. Richard Ishler; Chester, Grant W. Bamberger; Clarion, Theodore R. Koenig; Clearfield, Fred Pease; Clinton, George J. Treires; Columbia, James F. Youngkin; Crawford, Robert L. Kirkpatrick; Cumberland, Hans S. Roe; Dauphin, Nathan Sussman; Delaware, Richard H. Flandreau; Elk-Cameron, James L. Hackett, Sr.; Erie, Robert L. Loeb; Fayette, Harold L. Wilt; Franklin, Albert W. Freeman; Greene, William W. Bartholomew; Huntingdon, Thomas S. Mainzer; Indiana, Harold L. Edison; Jefferson, Franklin S. Bizousky; Lackawanna, Joseph J. O'Brien; Lancaster, Charles H. Kurtz; Lawrence, Gerald H. Weiner; Lebanon, C. Ray Bell; Lehigh, Frederick R. Bausch, Jr.; Luzerne, Donald F. Closterman; Lycoming, Wilfred W. Wilcox; McKean, Ralph E. Hockenberry; Mercer, Robert E. Sass; Mifflin-Juniata, John R.W. Hunter, Jr.; Monroe, Claus G. Jordan; Montgomery, Rudolph K. Glocker; Montour, Isaac L. Messmore; Northampton, Walter J. Filipek; Northumberland, Nicholas Spock; Perry, Frank A. Belmont; Philadelphia, Charles M. Thompson; Potter, Herman C. Mosch; Schuylkill, Joseph T. Marconis; Somerset, Alexander Solosko; Susquehanna, Raymond C. Davis; Tioga, Ivan T. Brechbill; Union, John S. Purnell, Sr.; Venango, Frank Esparraguera; Warren, Donald J. Furman; Washington, Herbert J. Levin; Wayne-Pike, Howard R. Patton; Westmoreland, Leslie S. Pierce; Wyoming, John S. Rinehimer, Jr.; York, William C. Langston.

Remarks of President of Pennsylvania Bar Association

The Honorable H. Reginald Belden, a guest of the Society and president of the Pennsylvania Bar Association delivered the following remarks to the House:

Mr. Speaker, members of the House of Delegates, gentlemen. I am very happy to have the honor to represent the Pennsylvania Bar Association before this House. Mr. Speaker, I thank you for the invitation.

First I would like to say that my wife and I are most happy to have been assigned to Dr. Flannery and his charming wife— they certainly have been delightful hosts.

Last night when your Speaker asked me whether I would like to make some remarks, I told him that if the agenda would permit, I would like to have about six minutes. I am afraid he has spoken for six minutes of your time.

The problems of *both* of our professions are becoming increasingly more complex— and those problems are *not dissimilar*— with public officials making statements which are derogatory toward *both* the medical profession and the legal profession, and with the public being deliberately told that there should be a *plague* on *both* our houses.

We, who normally pursue our work in a quiet and dignified way are sometimes *forced* to take *more aggressive positions* in order to avoid the possibility that the members of the public— your patients and our clients— may be misled, to their detriment and ours, by the careless and unfounded accusations made by those who, by reason of their positions, are able to attract the attention of the news media and capture the headlines.

I believe it to be *most important* for our two professions to work together on matters which are of *mutual interest.* Two of these subjects are medical malpractice suits and medical malpractice insurance.

We are as concerned as you by a statement which was made in January 1971 by the then Chief Deputy Insurance Commissioner A. John Smither in a report to Insurance Commissioner George F. Reed. Mr. Smither said in that report that suits against physicians have been increasing so rapidly that they threaten the quality of medical care; that the medical profession is foregoing *many useful techniques* for fear of courts and juries; that malpractice litigation is now considered an *occupational hazard* so *great* as to affect medical school enrollment; and that greatly increased premiums for medical malpractice insurance have reflected the rising incidence of claims.

In his report Mr. Smither called attention to the fact that in 1969 Insurance Commissioner David Maxwell had formed an ad hoc committee of medical, legal, and insurance representatives to work toward the formulation of a long-range solution of the overall medical malpractice insurance problem. On that committee were two representatives of the insurance industry, seven doctors, and three lawyers.

I have read the report of the work which was done by that ad hoc committee from the date of its formation until January 1971, and I am *impressed* with the fact that much could be accomplished by the continuance of the work of that committee. Unfortunately, the ad hoc committee apparently *ceased* to *function* with the change of administration in Harrisburg in January of this year.

Three weeks ago I attended the Philadelphia Bench-Bar Conference at Buck Hill Falls, and while there I had a conference with Arnold M. Kessler, a Philadelphia lawyer who was a member of the ad hoc committee. Mr. Kessler suggested that in the apparent absence of any interest on the part of the present insurance department of the Commonwealth, perhaps the Pennsylvania Bar Association and the Pennsylvania Medical Society should consider *joint sponsorship* of a continuance of the ad hoc committee.

At a meeting of the Board of Governors of the Pennsylvania Bar Association on October 2, I asked for and ob-

tained authority to discuss this subject with the President of the Pennsylvania Medical Society and with this House of Delegates, and I also obtained the further authority to proceed with the reactivation of the ad hoc committee in *joint sponsorship* with the Pennsylvania Medical Society, if the idea is approved by your society.

Among the things which might be considered by such a joint committee, or joint council, are the following:

(1.) "Mal-Occurrence" insurance coverance which a patient could purchase to protect him against an unsatisfactory result. Clearly, many law suits are predicated, not upon malpractice, but upon *mal-occurrence*, which is *not* the result of professional negligence and for which a physician should *not* be held responsible any more than a lawyer should be held responsible for losing a case when he has *prepared* and *tried* the case with *dilligence* and *professional skill.*

(2.) Medical-legal screening panels composed of doctors and lawyers, and representing a *joint effort* on the part of the two professions to screen the *just* claims from the *unjust.*

(3.) The creation of insurance industry "pools" or "syndicates" as a means of broadening the industry base for the writing of medical malpractice insurance.

(4.) The taking of medical testimony by *video tape deposition* in the doctor's office rather than requiring him to sit in a court room while other witnesses testify, then to spend hours on the witness stand.

These are only a few of the subjects which could be explored by such a joint council as I have envisioned. If the Pennsylvania Medical Society sees *merit* in this proposal, the Pennsylvania Bar Association is prepared to *act jointly* with you.

Thank you for the opportunity to make these remarks.

"Dr. Rial: Thank you very much, President Belden. I am sure that you realize from the reception your remarks received that we concur with this increased liaison with our profession to our mutual interest. Unless there is objection from the House of Delegates, I presume that you will authorize the President to proceed with appropriate negotiations. Hearing none, Dr. Rosemond, you are authorized to proceed in this area."

Report of the Reference Committee on Standing and Special Committees

James F. Welsh, M.D., Chairman, presented the following report which was adopted as read.

Committee on Aid to Education *(Official Reports Book - page 55)*

Mr. Speaker, we commend the work of the Committee which shows the continuing interest of the Society in providing financial aid to medical students. We note the Committee's decision to change the terms of the loans granted from the Educational Fund. The forgiveness of the interest charge and the deferment of principal payments for five years will hopefully encourage more borrowers to take any additional training within the state and stay in Pennsylvania to practice. We commend the Committee's efforts to encourage the graduating physicians to remain and practice in Pennsylvania.

Mr. Speaker, we RECOMMEND that the $8.00 allotment per active dues member be continued for 1972.

Mr. Speaker, we further RECOMMEND that the Board of Trustees instruct the Finance Committee to continue to study the feasibility of decreasing the allotment in future years.

Annual Report of the Educational and Scientific Trust

Your Reference Committee urges all members of the Society to continue making contributions to the Educational and Scientific Trust of the Pennsylvania Medical Society and to AMA-ERF on a regular basis.

Mr. Speaker, we RECOMMEND that this Annual Report be filed for information.

Advisory Committee to the Woman's Auxiliary *(Official Reports Book page 56)*

We commend the work of the Committee.

Mr. Speaker, we RECOMMEND that this report be filed for information.

Report of the President of the Woman's Auxiliary (Appendix K.)

Your Reference Committee notes the goals and accomplishments that have been achieved by the Woman's Auxiliary. We commend the Auxiliary for their efforts, with special recognition to Mrs. Leroy A. Gehris for her dedication and leadership. We recognize Mrs. Gehris' appeal for membership to the Auxiliary and urge every physician's wife to join this organization.

Mr. Speaker, we RECOMMEND this portion of the report be adopted.

Committee on Relationships with Allied Professions *(Official Reports Book - page 63)*

We commend the Committee for their work with the nursing and podiatry professions. We urge this Committee to continue the "pilot program" in discussing the problems between medicine and nursing.

Mr. Speaker, we RECOMMEND that this portion of the report be adopted.

Mr. Speaker, we further RECOMMEND that the Board of Trustees instruct the Committee to establish liaison with schools of allied health professions in the state.

Committee on Medical Benevolence *(Official Reports Book - page 64)*

Your Reference Committee understands that on March 17, 1971, the Board of Trustees of the Pennsylvania Medical Society approved the recommendation that the Board change the objectives of this fund from strictly income and authorize Vestaur Corporation to handle the fund as a combined growth and income account. We note that the Vestaur Corporation assured the Board of Trustees of the Pennsylvania Medical Society that if the objectives of the fund could be changed, "invasion of the principal would not effect the overall total." We commend the work of the Committee.

Mr. Speaker, we RECOMMEND the approval of the Medical Benevolence Committee's recommendation for the continuation of the $1.00 allotment per active dues member in 1972.

Mr. Speaker, we further RECOMMEND that the Board of Trustees instruct the Finance Committee to continue to study the feasibility of decreasing the $1.00 allotment in future years.

Committee on Objectives *(Official Reports Book - page 64)*

Mr. Speaker, we RECOMMEND that the Pennsylvania Medical Society continue to support its long range objectives adopted by the 1970 House of Delegates.

Committee on Discipline *(Official Reports Book - page 65)*

We commend the Committee for the compilation of the Grievance and Disciplinary Actions Survey of 1970.

Mr. Speaker, we RECOMMEND that this report be filed for information.

Dr. Rosemond's Address—Recommendation Concerning the Activity of Censors *(paragraph 22 and 23, page 1)*

Your Reference Committee agrees with Dr. Rosemond's remarks concerning county and state society censors in which he suggests that they should do more than investigate only when specific complaints are submitted. We recognize that a change in the Bylaws is necessary to accomplish this.

Mr. Speaker, we RECOMMEND that this matter be referred to the Committee on Constitution and Bylaws for study.

Mr. Speaker, we RECOMMEND that the portion of Dr. Rosemond's address concerning maintenance of proper rapport with the Pennsylvania State Board of Medical Education and Licensure be filed for information.

Committee on Medicine and Religion *(Official Reports Book - Page 67)*

We commend the work of the Committee and we are looking forward to more activity in the future.

Mr. Speaker, we RECOMMEND that this report be filed for information.

Committee on General Practice *(Official Reports Book - page 67)*

Mr. Speaker, the Special Committee on General Practice recommended that the Committee be discharged. Testimony at this hearing revealed that there is still a shortage of general practitioners in Pennsylvania, and that the medical schools have not fulfilled their commitments to produce more general practitioners. With the problem still prevalent, we feel that the discharge of this Committee is premature.

Mr. Speaker, we RECOMMEND that this Committee not be discharged.

Mr. Speaker, we RECOMMEND that the Committee on General Practice should continue to have adequate representation from the members of the Pennsylvania Academy of General Practice.

Committee to Study Relationships Between Medicine and Osteopathy *(Official Reports Book - page 67)*

We note that representatives of the Board of Trustees of the Pennsylvania Medical Society have been meeting with representatives of the Board of Directors of the Pennsylvania Osteopathic Medical Association. We commend both the Committee and the Board of Trustees for seeking better liaison between the Pennsylvania Medical Society and the Pennsylvania Osteopathic Medical Association.

Mr. Speaker, we RECOMMEND that this report be filed for information.

Lay Advisory Committee on Health Care *(Official Reports Book - page 68)*

We commend this Committee for its organizational efforts and we are looking forward to specific recommendations in the health and medical care cost and manpower areas that will be of possible benefit for both the public and the profession.

Mr. Speaker, we RECOMMEND that this report be filed for information.

Report of the Reference Committee on Reports of Officers

Anthony T. Merski, M.D., Chairman, presented the following report which was adopted as read.

Report of the Board of Trustees and Councilors *(Official Reports Book - pages 14-24)*

The Reference Committee reviewed the entire comprehensive report of the Board. Especially noted is the adequate disposition of the resolutions referred to it by the 1970 House of Delegates. No specific recommendations were made, the content being primarily information.

Mr. Speaker, we RECOMMEND that the report of the Board of Trustees and Councilors be filed for information

Report of the Secretary *(Official Reports Book - pages 25-26)*

Your Reference Committee carefully reviewed the contents of this report. We noted with special interest the final disposition of Resolution 70-15 "Definitive Interpretation of Sole Arbiter Principle" by the A.M.A. Judicial Council.

Mr. Speaker, we RECOMMEND that the report of the Secretary be filed for information.

Report of Executive Director *(Official Reports Book - pages 27-30)*

Your Reference Committee carefully reviewed this report submitted as information.

Mr. Speaker, we RECOMMEND that the report of the Executive Director be filed for information.

Report of the Treasurer *(Official Reports Book - pages 30-31)*

Your Reference Committee reviewed the report of the Treasurer. We are pleased to note a surplus in the General Fund for the year 1970.

Mr. Speaker, we RECOMMEND that the report of the Treasurer be filed for information.

Report of the Accountant *(Official Reports Book - pages 31-32)*

Your Reference Committee reviewed the entire report of the PMS public accountant and found no adverse comments or recommendations.

Mr. Speaker, we RECOMMEND that the report of the Accountant be filed for information.

Reports of the Individual Trustees and Councilors *(Official Reports Book - pages 36-54) (except that portion of the Third District Report dealing with question 7 as answered by Lackawanna County)*

Your Reference Committee reviewed all reports of each Councilor District. The reports are informational requiring no action.

Mr. Speaker, we RECOMMEND the reports of Individual Trustees and Councilors be filed for information.

Report of the Pennsylvania Delegation to the AMA also Supplemental Report to AMA House of Delegates *(Official Reports Book - pages 99-100, except items No. 2 and No. 3)*

The Delegation under the Chairmanship of Thomas W. McCreary, Sr., M.D., voted to nominate Russell B. Roth, M.D., for the office of Speaker of the House in 1971 and to nominate him for President-Elect of the AMA in 1972, which this House of Delegates already supported unanimously in the adoption of Resolution 71-14.

The Pennsylvania Delegation was reduced from twelve to eleven members based on active membership. Thomas W. McCreary, Sr., M.D., resigned from the Delegation after serving eight years as Alternate and fifteen years as Delegate.

The Pennsylvania House of Delegates owes Dr. McCreary rousing heartfelt thanks for his many years of splendid service.

We also noted that Wendell B. Gordon, M.D., and Samuel B. Hadden, M.D., who served many long and fruitful years as members of the delegation, are retiring. This House of Delegates owes these gentlemen a considerable debt of thanks for their hard work.

In the two sessions the Pennsylvania Delegation to the AMA introduced six resolutions. The Reference Committee wishes to note with pride the present positions of the AMA manned by Pennsylvania physicians.

Russell B. Roth, M.D., was unanimously elected Speaker of the House of Delegates for the third term.

Elmer G. Shelley, M.D., continues as Chairman of the AMA Judicial Council.

William A. Sodeman, M.D., is Chairman of the Council on Medical Education.

M. Louise Gloeckner, M.D., is a member of the Council on Constitution and Bylaws.

Mr. Speaker, we RECOMMEND that the report of the Pennsylvania Delegation to the AMA and the Supplemental report be filed for information, and that commendations be extended to the above members.

(Secretary's Note: It was also stated that William B. West, M.D., Huntingdon, is a member of the AmPAC Board of Directors.)

Board of Trustees and Councilors - Supplemental Report A *(Official Reports Book - page 101)*

Your Reference Committee carefully examined the entire Supplemental Report. The contents are intended as information.

Mr. Speaker, we RECOMMEND that Supplemental Report A of the Board of Trustees and Councilors be filed for information.

Address of the President - William A. Limberger, M.D. *(November PENNSYLVANIA MEDICINE)*

Dr. Limberger's excellent address captured the spirit of the Pennsylvania Medical Society, a society ambitiously engaged in progressive programs, enthusiastically resolving new and old problems with an outlook for better medical care in Pennsylvania.

An interesting highlight was the presentation of facts and figures and what it takes to be President of the Pennsylvania Medical Society. The summary of his personal service to our Society is a feat worthy of applause.

Dr. Limberger recommends that this House of Delegates again reaffirm its support of PaMPAC.

The Reference Committee recognizes the force that legislation can bring to bear on American medicine. It is, therefore, imperative that physicians support legislators who are sympathetic to the goals and objectives of the Pennsylvania Medical Society. PaMPAC is our instrumentality for achieving this end.

Mr. Speaker, the Reference Committee RECOMMENDS that this House of Delegates reaffirm its support of PaMPAC and urge all members of PMS to become active members of PaMPAC.

Dr. Limberger recommends that each county medical society contact all physicians in their county who are not members of their Society and enroll them.

Your Reference Committee recognizes the importance of full representation of all physicians eligible for membership in the Pennsylvania Medical Society. It also recognizes a new potential source in the interns and residents who are now eligible for membership. Facts obtained in a recent survey of all physicians licensed in Pennsylvania reveal a need to contact all physicians at the county level.

Your Reference Committee feels that no such membership drive is effective without constant review and follow up. It believes that the most effective method currently available is to urge the Trustee and Councilor of each district to contact each county medical society in his district at least annually to ask for a progress report from each of them with regard to membership recruitment. This subject should be high on the agenda of each councilor at the time of his councilor district meetings.

Mr. Speaker, the Reference Committee RECOMMENDS that each county medical society be urged to enroll nonmembers, that they amend their bylaws so that interns and residents may be eligible for membership and that each Trustee and Councilor provide leadership for membership recruitment in his district.

Address of the President-Elect - George P. Rosemond, M.D., F.A.C.S. *(November PENNSYLVANIA MEDICINE)*

The Reference Committee commends Dr. Rosemond for his excellent presentation and deep insight into the purpose and need of the Pennsylvania Medical Society.

The President-Elect recommends a total reevaluation of dollar priorities by our Finance Committee and the Board of Trustees. The Reference Committee believes that this is of utmost importance. The Committee was advised by the Chairman of the Finance Committee that this is an ongoing activity of the Finance Committee and the Board of Trustees at this time. The Reference Committee urges the

Board of Trustees and the Finance Committee to continue to give careful consideration to priorities especially in view of increasing costs and the probability of a dues increase. The Reference Committee believes that any ineffective programs should be eliminated.

Mr. Speaker, your Reference Committee RECOMMENDS that the Finance Committee and the Board of Trustees continue its review of dollar priorities.

Dr. Rosemond notes that strong support for PaMPAC is urgent by all of the counties if th's organization is to maximize its effectiveness. Mr. Speaker, your Reference Committee RECOMMENDS that the State Society strongly urge the six reluctant counties to include PaMPAC in their billing.

Resolution 71-1 *(Official Reports Book - page 34)*

Subject: AMA Delegation Report and Plans

Introduced by: John L. Steigerwalt, M.D.
in behalf of the
Montgomery County Medical Society

Author: John L. Steigerwalt, M.D.

WHEREAS, The years ahead promise to be some of the most important ones which have faced the practice of medicine in our lifetime; and

WHEREAS, The actions and programs of Pennsylvania doctors are brought before the AMA policy body by the Pennsylvania Delegation; and

WHEREAS, Many questions of policy are formulated by the AMA House of Delegates which questions may not be known by nor available to this House; and

WHEREAS, The Pennsylvania Delegation should represent the views of this House; therefore be it

RESOLVED, That the Chairman of the Pennsylvania Delegation to the House of Delegates of the AMA, each year at the annual session of this House, shall deliver a report on the Delegation's actions the past year; and be it further

RESOLVED, That a report also be given by the Chairman of the Pennsylvania Delegation setting forth the objectives of the Delegation for the year ahead.

The Reference Committee sees merit in this resolution. Testimony before the Reference Committee by the sponsor of the resolution indicated that the report by the Chairman of the Pennsylvania Delegation to the AMA should be in the form of a brief oral report delivered each year before this House of Delegates. We believe that a report personally delivered in the House by the Chairman of the Delegation will be of significant value. Mr. Speaker, your Reference Committee RECOMMENDS the adoption of this resolution.

Resolution 71-2 *(Official Reports Book - page 134)*

Subject: Monthly Board Meetings

Introduced by: John L. Steigerwalt, M.D.
in behalf of the
Montgomery County Medical Society

Author: John L. Steigerwalt, M.D.

WHEREAS, Those of us serving on Boards of Trustees at a County level find that the work and duties of these Boards has increased during recent years; and

WHEREAS, It has become desirable and indeed necessary for these Boards to meet monthly; and

WHEREAS, We note that very often there exists a delay in being able to receive reports from the Board of the State Society due to a quarterly meeting schedule; therefore be it

RESOLVED, That this House respectfully suggests and recommends to the Board of Trustees of the Pennsylvania Medical Society that they consider meeting on a monthly basis in order that communication and timely efforts can be improved and accomplished.

Your Reference Committee believes that it is inefficient and time-consuming as well as costly to have monthly meetings of the Board of Trustees. The Reference Committee noted that there is a proposed Bylaw change before this House which, if adopted, will create an Executive Committee of the Board of Trustees which, at the prerogative of the Board could be empowered to implement urgent business between meetings of the Board itself. The Reference Committee believes this is a far more efficient way of doing business.

The Reference Committee also notes that, in addition to attending meetings of the Board, a Trustee serves on many committees of the Board. The total amount of time devoted to the Board and Board Committees is already considerable. These gentlemen deserve our thanks for the amount of time which they so generously donate on behalf of our Society.

Mr. Speaker, your Reference Committee RECOMMENDS that Resolution No. 71-2 be rejected.

Resolution 71-10 *(Official Reports Book - page 136)*

Subject: Establishment of Code Regarding Names for Professional Associations/Corporations

Introduced by: G. Winfield Yarnall, M.D. in behalf of the Dauphin County Medical Society

Author: G. Winfield Yarnall, M.D.

WHEREAS, Many physicians in Pennsylvania are considering the incorporation of their medical practice as a professional association; and

WHEREAS, A number of incorporated medical practice groups and their individual medical practitioners thus far have used the titles of their medical specialties for their corporate name rather than their own name or names of their associates; and

WHEREAS, It is believed this practice of identifying specialties rather than the names of the medical practitioners will become confusing to patients and physicians alike if allowed to continue; and

WHEREAS, In the past, the custom has been to identify the physician as the licensed practitioner and not his type of practice; therefore be it

RESOLVED, That the Pennsylvania Medical Society establish a uniform code for members interested in incorporating their medical practice as a professional association and that this code include the requirement that the name of the medical practitioner and/or practitioners be included in the title of the incorporated name and not the name of the type of medical practice; and in addition include such other requirements as the Pennsylvania Medical Society may consider necessary regarding the proper ethical notification of the incorporated name to patients and physicians by letter, newspaper, telephone directory and office sign.

Your Reference Committee recognizes the value of establishing some guidelines concerning the names for professional associations and corporations. The Reference Committee believes this matter should receive immediate attention and that the guidelines should be widely circulated by appropriate means to the membership. As the resolution currently stands, the Reference Committee feels that the Resolved clause should be clarified.

Mr. Speaker, your Reference Committee RECOMMENDS adoption of a substitute resolved clause as follows:

RESOLVED, That the Pennsylvania Medical Society establish guidelines covering the ethics of the selection and the use of names by members interested in incorporating their medical practice as a professional association or as a professional corporation.

Mr. Speaker, we RECOMMEND that Substitute Resolution 71-10 be referred to the Board of Trustees and to the Judicial Council with the recommendation that they take immediate action.

Opening Statement of Chairman of the Finance Committee

The Reference Committee reviewed the Chairman's statement. The Chairman was present during the open hearings and answered questions with regard to the financial status of the Society. There was little testimony either for or against a dues increase at the open hearing. Your Reference Committee, however, supports the concept of a reasonable dues increase to offset the effects of inflation and the added costs of new programs approved by this House of Delegates. There was no unanimity among the Committee as to the dollar amount of increase needed. The Reference Committee again emphasizes the need for the Finance Committee to increase its scrutiny of unnecessary and inappropriately funded programs and to eliminate these from budgetary support so as to keep the increase in dues to a minimal amount. (Adopted by the House)

Mr. Speaker, your Reference Committee RECOMMENDS that the opening statement of the Chairman of the Finance Committee be filed for information.

Report of the Reference Committee on Public Service

Kenneth F. Miller, M.D., Chairman, presented the following report of the Committee which was adopted as read:

Report of the Committee on Objectives — Recommendation No. 4 *(Official Reports Book, Page 65)*

Report of the Committee on Objectives — Recommendation No. 5 *(Official Reports Book, Page 65)*

Report of the Council on Public Service — Students, Interns, and Residents *(Official Reports Book, Page 86)*

The Reference Committee agrees in principle with Recommendation 4 of the Committee on Objectives. However, we recommend that it be amended for clarity as follows: The Committee recommends that the Society give priority to the involvement of young physicians in organized medicine by urging county societies, in conjunction with the Council on Public Service to initiate personal contact at the county level.

Mr. Speaker, The Committee RECOMMENDS that Recommendation No. 4 of the Committee on Objectives be accepted as amended and referred to the Council on Public Service.

The Reference Committee feels that while improved communications with directors of medical education is certainly desirable, it would have little effect in the recruitment of young physicians for membership in organized medicine. Effective recruitment must begin in the medical schools and before.

The Committee believes that now is the time to establish closer rapport with students, interns, and residents and recommends efforts such as:

Encouraging all types of personal relationships between individual physicians and individual students, interns and residents;

Re-emphasizing the Society's continued support of the MECO and Appalachia programs;

Holding informal gatherings with county society involvement at which members and students would feel free to discuss common interests and problems.

Mr. Speaker, we RECOMMEND adoption of this portion of the Reference Committee Report.

Report of the Council on Public Service — Membership Campaign *(Official Reports Book, Pages 87 and 88)*

It is interesting to note that many non-members of our Society have stated that they have never been asked to become members. The Committee hopes that our membership will become more aware of this fact, and recognize the responsibility of each member in this matter.

Mr. Speaker, We RECOMMEND that this portion of the report be filed for information.

Introduction, Report of the Council on Public Service *(Official Reports Book, Pages 80 and 81)*

Comments, Address of Dr. Limberger

The Reference Committee commends for your reading the introduction of the Report of the Council on Public Service.

Dr. Limberger's comments on communications, provide an excellent presentation of the many problems involved.

Mr. Speaker, we RECOMMEND that Dr. Limberger's comments on communications be referred to the Council on Public Service.

Report of the Council on Public Service — Rural Health *(Official Reports Book, Page 87)*

Supplemental Report - Board of Trustees

Comments, Address of Dr. Rosemond

The Committee doubts that manpower for rural health

care should be provided as part of the military draft. It seems obvious that rural deferments will only result in an increase in the total number of physicians drafted. The committee recommends consideration of all alternatives, including a government-sponsored draft, by a proper committee of this Society as recommended by Dr. Rosemond.

The Committee agrees with the action taken by the Board authorizing the Council on Public Service to inquire informally into the availability of funds for establishing mobile health care units for rural areas in Pennsylvania.

Mr. Speaker, We RECOMMEND adoption of this portion of the Reference Committee Report.

Remainder of the Report of the Council on Public Service *(Official Reports Book, Pages 80 through 89)*

The Council and staff are to be commended for the production of the 60-minute documentary telecast at one-twelfth the usual cost. It should be noted that the proposed budget contains funds for the production of more documentaries in the coming year.

The Society is indebted to Dr. Clarence A. Tinsman and his successor, Dr. David A. Smith, for their generous contributions of time and effort in producing the weekly radio program.

The Society's awards programs are extremely important in the enhancement of our public relations program. The Reference Committee urges county societies to be more active in presenting nominations for the Benjamin Rush Awards and should actively encourage nominations from newsmen for the Walter F. Donaldson Awards.

The Committee strongly urges that more members make themselves available for the Speakers' Bureau. This experience is always rewarding in greater rapport between the physician representing the Society and the general public.

The Committee urges each county society to foster the formation and continued interest in "Careers in Health Assemblies and Clubs" for students of junior and senior high and vocational technical schools.

The State Society stands ready to distribute posters, slides and flip charts for professional organizations as well as to the general public. There are also public relations aids for county societies including a well-stocked film library and special writing projects.

The Committee RECOMMENDS continuing support of the Pennsylvania Society of the American Association of Medical Assistants by county and state societies.

The Committee encourages involvement at the county society level in medically related community affairs.

The committee reviewed every item in the Council Report although it reported on only a few. The Council is to be highly commended for the scope of its activities in spite of the restrictions imposed by a very limited budget.

Mr. Speaker, The Committee RECOMMENDS the adoption of the Report of the Reference Committee on Public Service as a whole.

Report of the Reference Committee on Education and Science

Malcolm W. Miller, M.D., Chairman, presented the following report of the Committee, which was adopted as read:

Report of the Council on Education and Science *(Official Reports Book, pages 89-98)*

The Reference Committee has reviewed the Council's report which is comprehensive and documents carefully the many items referred to it for study and/or implementation. The introductory statement indicating the "torrential cascade" of activities with which they are faced and the time-consuming nature of their activities is well understood and appreciated by this Committee.

The Council should be complimented for implementing the 1970 resolutions referred to them. We wish to cite for special commendation their activities in the drug abuse area. This program should yield results in the near future.

A brief comment was made regarding Resolution No. 68-32 concerning study of cirrhosis and alcohol. The Council is not a research council and we are satisfied that they have done as much as possible in carrying out the intent of that resolution.

Mr. Speaker, I RECOMMEND the adoption of this portion of the Reference Committee report.

A number of special projects are worthy of commendation. The Council is developing an educational package program on personal health practices of the disadvantaged. It is noted that the program would focus its attention on such health practices of the poor.

The concept of educational program consulting services to community hospitals is extremely up-to-date and a worthwhile project. The Council is to be commended for its initiative and development of community educational activities.

The most significant activities in the Council's report relating to education were the development of guidelines for peer review activities, the incorporation and preliminary organization of the Pennsylvania Medical Continuing Education Institute, and recommended changes to the AMA Physician's Recognition Award. These activities constitute a solid total educational package aimed toward the improvement of medical practice in Pennsylvania. Testimony at the Reference Committee hearing indicated that significant changes will be taking place in the AMA Physician's Recognition Award criteria allowing educational activities at the community level to receive more credit. The Reference Committee urges the Council on Education and Science to continue its efforts at the AMA level for reasonable changes in the award criteria.

The Reference Committee notes that there are six commissions assisting the Council in its activities. Their programs seem to have been well planned. The Reference Committee agrees with the Council's direction of activities.

The list of priorities for 1971 and 1972 of the Council reflect desirable goals. We would suggest that the Council consider another priority— a method of accrediting Pennsylvania continuing medical education programs to assure that they meet the continuing education membership requirement.

Mr. Speaker, I RECOMMEND the adoption of this portion of the Reference Committee report.

Papanicolau Test *(Supplemental Report B, Board of Trustees and Councilors - Appendix J)*

The Reference Committee concurs with Supplemental Report B regarding the Papanicolau Test for cancer of the

cervix, and recommends to this House of Delegates that the position adopted by the Board of Trustees be endorsed.

Mr. Speaker, I RECOMMEND the approval of the position of the Board of Trustees and Councilors regarding the Papanicolau Test.

Committee on Objectives, Recommendation Two *(Official Reports Book, pages 64-65)*

The Reference Committee concurs with the recommendation of the Committee on Objectives. Our hearing indicated that the Council on Education and Science has cooperated with the Pennsylvania Academy of Family Physicians in meeting with the deans of the medical colleges in the State regarding curriculum changes toward the production of family practitioners. We would remind the Council of its past cooperation with the Academy and recommend that the Council continue this relationship.

Mr. Speaker, I RECOMMEND the adoption of recommendation number two of the Committee on Objectives.

Cosponsorship of MECO Program *(Supplemental Report B, Board of Trustees and Councilors - Appendix J.)*

The Board of Trustees and Councilors has approved continued cosponsorship of the Medical Education Community Orientation program (MECO) of the Student American Medical Association. This is one of the most worthwhile programs in community medicine in Pennsylvania and we would strongly support the action of the Board of Trustees and Councilors and commend the Student American Medical Association for its dedication to the high ideals and principles of medical practice.

Mr. Speaker, I RECOMMEND the approval of the action by the Board of Trustees and Councilors in continuing Society cosponsorship of the MECO program.

Shortage of Practicing Physicians, Resolution No. 71-16 *(Supplemental Report B, Board of Trustees and Councilors - Appendix J.)*

Introduced by: Ernest L. Abernathy, M.D. in behalf of the Washington Medical Society

Author: Ernest L. Abernathy, M.D.

WHEREAS, There is a continuing and increasing shortage of practicing physicians in Pennsylvania, particularly in the smaller communities; and

WHEREAS, The major medical schools in the Commonwealth have recently made distinct and praiseworthy efforts to increase the number of students enrolled; therefore be it

RESOLVED, That the Pennsylvania Medical Society adopt a continuing policy of communication with the appropriate authorities in the various medical schools of the Commonwealth to encourage those schools to accept a majority of applicants from the State of Pennsylvania, systematically encourage those students to enter medical practice in their local communities, and structure their teaching with this end in view; and be it further

RESOLVED, That the intent of this resolution is to ask the Pennsylvania Medical Society with all means at its disposal to insure clear understanding on the part of the medical schools that the Society believes firmly that the primary object of a medical school is to turn out practicing physicians, and that, while research programs and various programs of independent study may be useful as adjuncts to this purpose, they are not in themselves the primary purpose of a medical education.

Your Reference Committee concurs with Supplemental Report B of the Board of Trustees and Councilors regarding the position statement on the production of health professionals developed by the Pennsylvania Medical Society and the deans of schools of medicine in Pennsylvania.

Mr. Speaker, I RECOMMEND the adoption of this portion of Supplemental Report B.

The Reference Committee is also in sympathy with the intent of Resolution No. 71-16, but the intent would be better expressed by the following substitute resolution:

RESOLVED, That the Pennsylvania Medical Society exert all means at its disposal to insure clear understanding on the part of the medical schools that the Society believes firmly that the primary objective of a medical school is to turn out practicing physicians.

RESOLVED, That the Pennsylvania Medical Society communicate with the appropriate authorities in Pennsylvania medical schools, emphasizing the urgent need for rural physicians, and encourage those schools to select more applicants, otherwise qualified, who are residents in the rural areas, in the hope that they may return to such areas to provide medical services.

Mr. Speaker, I RECOMMEND the adoption of the substitute resolution.

Restrictions for Prescribing Amphetamines, Resolution No. 71-7 *(Official Reports Book, pages 135-136; Supplemental Report B, Board of Trustees and Councilors)*

Introduced by: Joseph V. Caliguiri, M.D. in behalf of the Allegheny County Medical Society

Author: Cyril H. Wecht, M.D.

WHEREAS, There is an increasing amount of drug abuse involving amphetamines and other similar drugs such as amphetamine (Benzedrine), dextroamphetamine (Dexedrine), methamphetamine (Desoxyn or Methedrine), phenetrazine (Preludin), methylphenidate (Ritalyn), and diethylpropion HCL (Tenuate). In addition, there are various preparations containing methamphetamine plus a sedative such as Desdutal, Ambar and Eskatrol; and

WHEREAS, Physicians can contribute to the prevention and treatment of drug dependence and participate in the implementation of sound professional programs to cope with these problems; therefore be it

RESOLVED, That Pennsylvania physicians be urged by action of the House of Delegates to refrain from prescribing amphetamines except in special clinical conditions such as narcolepsy or hyperkinesis, and be it further

RESOLVED, That physicians be urged not to prescribe amphetamines for purpose of appetite control, and be it further

RESOLVED, That the Pennsylvania Pharmaceutical Association be informed of this resolution and be urged to cooperate with the medical profession in these efforts, and be it further

RESOLVED, That information regarding these problems and solutions for combating drug abuse be disseminated to the medical profession through the official publications of the state and county medical societies and to the public as soon as possible.

The Reference Committee concurs with the intent of Resolution No. 71-7 that limitations on prescribing of amphetamines be adopted. The Reference Committee hearing provided testimony that the Board of Trustees, at its October 3 meeting, adopted a position statement calling for a voluntary restriction on the use of amphetamines. Since this resolution is in harmony with the adopted policy by the Board of Trustees and Councilors and a positive contribution that the medical profession can make to the curbing of drug abuse, we recommend that the resolution be adopted.

Mr. Speaker, I RECOMMEND the adoption of Resolution No. 71-7.

Continuing Education Institute and Educational Requirement *(President's Address; President-Elect's Address)*

We approve the President's and President-Elect's recommendation of continued support for the Pennsylvania Medical Continuing Education Institute.

Mr. Speaker, I RECOMMEND the approval of this portion of the Reference Committee report.

We approve the President-Elect's recommendation for continued support of the membership continuing medical education requirement.

Mr. Speaker, I RECOMMEND the approval of this portion of the Reference Committee report.

Emergency Medical Care *(President's Address, President-Elect's Address)*

Both the President and President-Elect have called attention to the efforts of the Commission on Emergency Medical Services and the publishing of a white paper on Emergency Medical and Health Services in Pennsylvania. We support their recommendations that member physicians read this article.

Mr. Speaker, I RECOMMEND the approval of this portion of the Reference Committee report.

Environment *(President-Elect's Address)*

The President-Elect has urged the Society to accept the responsibility for increased activity in the planning process of our environmental problems. We approve and support his recommendation.

Mr. Speaker, I RECOMMEND the approval of this portion of the Reference Committee report.

Environmental Safeguard Award, Resolution No. 71-3 *(Official Reports Book, Page 134)*

Introduced by: R. William Alexander, M.D. in behalf of the Berks County Medical Society

Author: R. William Alexander, M.D.

WHEREAS, Programs have been proposed by all levels of society and government to promote pollution abatement and environmental control; and

WHEREAS, The medical profession has consistently advocated ecological protection of all forms of animal life; and

WHEREAS, It is an avowed purpose of the Pennsylvania Medical Society to promote and improve the health and well-being of the citizens of this Commonwealth; and

WHEREAS, It is the responsibility of the Department of Environmental Resources to establish standards of satisfactory control of the environment; therefore be it

RESOLVED, That the Pennsylvania Medical Society in cooperation with the component county society or counselor districts, establish an award that publicly recognizes and commends industries or communities meeting the Department of Environmental Resources standards, and thereby demonstrating a sincere concern for the health and welfare of the public.

The Reference Committee concurs with the objectives of this resolution which seek to recognize industries or communities meeting environmental standards. Testimony at our hearing indicated that the Board of Trustees, at its August 11 meeting, approved an Environmental Improvement Award recommended by the Council on Education and Science. The difference between the approved award and Resolution No. 71-3 is that Resolution No. 71-3 would commend industry or communities that meet standards that are established by law; whereas, the Society's newly approved award would commend those organizations or individuals that go beyond legal requirements.

We would recommend that the Environmental Improvement Recognition Award, established by the Board of Trustees and Councilors, be supported because it embraces the concepts of Resolution No. 71-3, but sets higher criteria. We would recommend that Resolution No. 71-3 be rejected because of its limitations.

Mr. Speaker, I RECOMMEND the rejection of Resolution No. 71-3.

Mr. Speaker, I RECOMMEND the approval of the action of the Board of Trustees and Councilors establishing the Environmental Improvement Recognition Award.

Mr. Speaker, I RECOMMEND the adoption of the report of the Reference Committee on Education and Science as a whole.

Report of the Reference Committee on Medical Service "A"

Robert A. Schein, M.D., Chairman, presented the following report of the Committee, which was adopted, as read.

Report of the Council on Medical Service *(Official Reports Book — pages 73-80)* and Supplemental Report A of the Council on Medical Service - Appendix F

Pennsylvania Blue Shield

In general, the Council has been diligent in carrying out liaison responsibilities with Blue Shield and is to be commended for its efforts.

Pennsylvania Blue Shield Report to the House of Delegates

Your Reference Committee has carefully perused the Blue Shield Report and is pleased to learn of the continued growth of Pennsylvania Blue Shield. Blue Shield should be encouraged to continue to improve the administration of its programs and to develop plans which will meet the rapidly changing health care needs of the future.

Mr. Speaker, your Reference Committee RECOMMENDS the Blue Shield Report be filed for information.

Subcommittee to Advise Blue Shield

Your Reference Committee commends the Council and its Subcommittee for its efforts in guiding Blue Shield in the development of the Prevailing Fee concept.

However, the Reference Committee noted that there are still numerous problems and considerable misunderstandings relative to the development of doctor profiles and their use in administration of the Prevailing Fee concept. The Council and its Subcommittee should continue efforts to resolve problems and clarify misunderstandings related to the Prevailing Fee Program.

Mr. Speaker, Your Reference Committee RECOMMENDS approval of this portion of the Reference Committee Report.

Pennsylvania Blue Shield Proposed plan "C" *(Official Reports Book — pages 101-103)* and Supplemental Report B of the Board of Trustees — Action No. 4- Appendix J

Your Reference Committee concurs with the Council's feeling that the offering of an additional Blue Shield Fee Schedule Program would not be in the best interest of the public or profession and in the long term would have an adverse effect on the Prevailing Fee Program.

Your Reference Committee urges Blue Shield to continue its efforts to upgrade the Plan B Fee Schedule, with the understanding that it will necessitate raising the income level for service benefits for Plan B.

Mr. Speaker, your Reference Committee RECOMMENDS approval of the recommendation of the Council on Medical Service on page 103 of the Official Reports Book.

Pennsylvania Blue Cross Plans

Your Reference Committee believes that close liaison with the Blue Cross Plans is essential for a better understanding and solution of mutual problems. The Council should continue efforts to improve relations with the Blue Cross Plans.

Western Pennsylvania PMS — Blue Cross Regional Steering Committee and Blue Cross District IV Utilization Review Proposal

Your Reference Committee was impressed with the activities of the Western Pennsylvania PMS — Blue Cross Regional Steering Committee and believes the Committee has proven to be an effective mechanism to develop claim processing and utilization review systems on a cooperative basis with Blue Cross.

However, it was noted that the Council has not been successful in organizing Regional Steering Committees in the other four Blue Cross service areas. Your Reference Committee concurs with the Council's intent to expand the Regional Steering Committee concept and to develop the Blue Cross District IV Utilization Review Proposal on a concurrent basis for all Blue Cross plans.

Mr. Speaker, your Reference Committee RECOMMENDS approval of this portion of the Reference Committee Report.

Supplemental Report B of the Board of Trustees — Action No. 3 — (Appendix J)

Your Reference Committee supports the action taken by the Board of Trustees to urge Blue Cross to expand the pre-admission testing program with Pennsylvania Blue Shield as a participant so that pre-admission studies may be conducted in an out-patient facility of a hospital or a physician's private office or laboratory.

Mr. Speaker, your Reference Committee RECOMMENDS approval of this portion of the Reference Committee Report.

Pennsylvania Medical Society Review Program

Your Reference Committee commends the Council for its efforts in the continued functioning of the Society Review Program and encourages the Council to continue its efforts to carry out this responsibility.

Mr. Speaker, your Reference Committee RECOMMENDS that the activity report for the Society's Review Program be filed for information.

Pennsylvania Department of Public Welfare

Your Reference Committee noted that there have been no significant improvements in the Commonwealth's Medical Assistance Program during the past year despite the Council's efforts to initiate change.

Your Reference Committee was pleased to learn that the Council requested and was granted an opportunity by the Pennsylvania Department of Public Welfare to review and comment on the proposed changes in Rules and regulations for licensing hospitals being developed by the Department.

Mr. Speaker, your Reference Committee RECOMMENDS that this portion of the Reference Committee Report be filed for information.

Professional Liability Insurance: Address of the President and Supplemental Report B of the Board of Trustees — Action No. 6 (Appendix J)

Your Reference Committee noted that the Board of Trustees has taken action naming Pepper, Hamilton and Scheetz as chief defense counsel for the Society's professional liability insurance program.

Your Reference Committee commends the Council for its outstanding efforts in resolving the mounting mal-

practice insurance problems confronting our members. The implementation of the PMS Professional Liability Insurance Program, June 1, 1971, provides the membership with one of the most progressive, comprehensive insurance programs ever offered to a medical group.

Mr. Speaker your Reference Committee RECOMMENDS that this portion of the Reference Committee Report be filed for information.

Medicare

Your Reference Committee noted the section of the Council's report relative to Medicare claim processing and ECF utilization review procedures. It is the feeling of the Reference Committee that the Council has exerted every effort to resolve these problems and is urged to continue these activities.

Mr. Speaker your Reference Committee RECOMMENDS approval of this portion of the Reference Committee Report.

Commission on Comprehensive Health Planning

Your Reference Committee noted the rather slow development of Comprehensive Health Planning activities in many parts of the Commonwealth.

However, in view of the continued efforts to implement Comprehensive Health Planning Programs, your Reference Committee urges the Commission on Comprehensive Health Planning to continue efforts to improve physician understanding and participation in Comprehensive Health Planning activities.

Mr. Speaker, your Reference Committee RECOMMENDS approval of this portion of the Reference Committee Report.

Committee on Objectives, Recommendation No. 3 *(Official Reports Book - page 64)*

Although no testimony was received regarding the concept that only educational funds should be used to finance post-graduate medical education, your Reference Committee believes that this matter requires considerable study and planning.

We have noted that there is a vast difference in the learning/service ratio from hospital to hospital. It was agreed there is a need for a system of cost accounting in hospitals to develop appropriate reimbursements and that medical service to patients provided by interns and residents should be considered reimbursable by third parties.

The educational portion of intern and residency program costs will require local, state, and federal funds, since there appears to be no other source available.

Since there does not appear to be a solution immediately available to the question of financing intern and residency programs, the Committee, therefore, recommends that this matter be referred to the appropriate councils or committees to continue to seek solutions to this question.

Mr. Speaker, your Reference Committee RECOMMENDS approval of this portion of the Reference Committee Report and that it be referred to the Board of Trustees for disposition.

Third Councilor District Report, Question No. 7, Lackawanna County *(Official Reports Book — pages 43-44)*

No testimony was presented relative to this question. It was the feeling of the Reference Committee that the Council on Medical Service has complied with the intent of the question raised by Lackawanna County relative to improving the effectiveness of organized medicine in terms of health care delivery, government involvement, and costs of health care. Your Reference Committee urges the Council to continue in these activities.

Mr. Speaker, your Reference Committee RECOMMENDS that this portion of the Reference Committee Report be filed for information.

Usual and Customary Fees for Commonwealth Program Resolution 71-11

Introduced by: Robert M. Kerr, M.D.
in behalf of the Luzerne
County Medical Society

Author: Robert M. Kerr, M.D.

WHEREAS, The usual and customary fee concept has always been an integral part of sound professional practice; and

WHEREAS, This concept has been accepted by the federal government as a basis for payment under Medicare; therefore be it

RESOLVED, That the Pennsylvania Medical Society reaffirm its position that such a concept is the only proper basis for continued highest quality care for all people in Pennsylvania; and be it further

RESOLVED, That the Pennsylvania Medical Society urge the Commonwealth of Pennsylvania to adopt such a concept for Title XIX patients as rapidly as is financially possible.

Your Reference Committee noted that Resolution 71-11 is consistent with past actions taken by the Board of Trustees and the House of Delegates. Your Reference Committee RECOMMENDS adoption of Resolution 71-11.

Resolution 71-15: Department of Public Welfare Payments to Hospitals - Resolution 71-15,

Introduced by: John D. Alexander, Jr., M.D.
in behalf of the
Philadelphia County Medical Society

Author: R. Robert Tyson, M.D.

WHEREAS, The Pennsylvania Department of Public Welfare has issued a statement that Section 9421.61 of the Medical Assistance Manual will be revised, effective October 1, 1971; and

WHEREAS, This revision requires that a copy of the patient discharge summary sheet on all inpatient cases must be

attached to every medical assistance invoice submitted to the fiscal intermediary for payment; and

WHEREAS, These summaries must be printed or typed; and

WHEREAS, These summaries will be subject to post utilization review before payment is made; and

WHEREAS, The imposition of this regulation will impose undue hardship on hospitals, particularly in metropolitan areas, by further delaying payments to these hospitals which already are under financial stress; therefore be it

RESOLVED, That this House of Delegates urge the Welfare Department to rescind this directive or modify it in such manner as may be appropriate to alleviate this undue delay in payment to hospitals for inpatient care rendered.

In considering Resolution 71-15, the Reference Committee agreed the pertinent information from the hospital record should be provided to third parties for legitimate reasons. However, it is not in the patient's best interest to transmit, in its entirety, the discharge summary or other information from the hospital record. Such indiscriminate dissemination of private information would only serve to violate the patient's right to privacy and the honored patient/doctor relationship.

Your Reference Committee RECOMMENDS adoption of Resolution 71-15.

Resolution 71-13: Seventy-two Hour Review Clause — Department of Public Welfare Memorandum No. 16

Introduced by: Herbert A. Friedman, M.D.,
in behalf of the Monroe
County Medical Society

Author: James C. Fahl, M.D.

WHEREAS, We, the membership of the Monroe County Medical Society, have conducted effective utilization review in compliance with Titles XVIII and XIX of Public Law 89-97 since its inception; and

WHEREAS, such review is pertinent to the proper delivery of medical care, it must be recognized that this form of peer review demands considerable time and effort on the part of many actively practicing physicians; it is therefore imperative that any revisions of current procedures be justified on the basis of better patient care and more efficient use of the physician's time; and

WHEREAS, the new regulation of the Pennsylvania Department of Welfare as stated in memorandum #16, dated April 16, 1971, requires a significant departure from existing procedures, namely the requirement that Medical Assistance in-patients be reviewed within 72 hours of hospital admission as to the medical necessity for hospitalization. This regulation discriminates against the Medical Assistance patient as he is singled out for review in contradistinction to any other patient; and

WHEREAS, all patients are initially reviewed for medical necessity for admission by the attending physician, it is clearly discriminatory to require re-review of one class of patients because of their lower economic status and accept the initial review of all other patients who happen to be economically better off. The arbitrary and discriminatory aspects of this regulation do not encourage better patient care and the physician-time required for review would tend to decrease the physician's efficiency; therefore be it

RESOLVED, that the Pennsylvania Medical Society strongly recommends that the Pennsylvania Department of Welfare strike the 72-hour review clause from its Utilization Review Regulations.

Testimony and correspondence received by the Reference Committee strongly supported the adoption of Resolution 71-13.

Mr. Speaker, your Reference Committee RECOMMENDS adoption of Resolution 71-13.

Commonwealth Medical Assistance Program Resolution 71-6 *(Official Reports Book — page 135)*

Introduced by: Joseph V. Caliguiri, M.D.
in behalf of the Allegheny
County Medical Society

WHEREAS, The physicians of Allegheny County pioneered the development of the hospital utilization review concept during the late 1950's; and

WHEREAS, Physicians in Pennsylvania have assumed the responsibility to develop effective health care cost control mechanisms and have actively supported hospital utilization review activities; and

WHEREAS, The Pennsylvania Department of Public Welfare has promulgated cumbersome, ineffective, useless, and unworkable regulations for the Commonwealth's Medical Assistance Programs; and

WHEREAS, The Department of Public Welfare has not demonstrated any sincere interest in discussing reasonable solutions to these problems; and

WHEREAS, The Department of Public Welfare has made little or no progress in improving the benefit structure and the administration of the Medical Assistance Program; and

WHEREAS, The administration and Rules and Regulations of the Medical Assistance Program do not serve the best interests of our disadvantaged citizens and are discriminatory; therefore be it

RESOLVED, That after a period of six months, unless a satisfactory welfare program is submitted by the Secretary of Welfare, the Pennsylvania Medical Society withdraw its

support of the Commonwealth's Medical Assistance Program and recommend that individual practitioners and hospital medical staffs not participate in the Medical Assistance Program; and be it further

RESOLVED, That consistent with the dictates of our conscience and the sense of our responsible service to the public interest we will render service to all patients regardless of their race, religion, creed, political affiliation, or ability to pay and will exert our best efforts in our patients' behalf and shall unselfishly devote our utmost ability, learning, and skill-to the treatment of our patients; and be it further

RESOLVED, The hospital medical staffs be urged to expand their hospital's utilization review plan to include all patients to assure a non-discriminatory uniform review process; and be it further

RESOLVED, That the Pennsylvania Medical Society continue to improve present and develop new utilization review techniques as is presently being carried out by the PMS - Medical Care Appraisal Project; and be it futher

RESOLVED, That this resolution be distributed to all members of the Pennsylvania Medical Society, county medical societies, and hospital medical staffs, requesting an indication of their support.

The Reference Committee noted the extraordinary dissatisfaction of physicians with the Medical Assistance Program, serious enough to strongly consider withdrawing support of this Program. Although your Reference Committee is in sympathy and agrees with the intent of the Resolution, we have concluded that the first resolve of Resolution 71-6 does not represent a practical solution for improving the Medical Assistance Program at this time.

Your Reference Committee was informed that the Secretary of Public Welfare recently responded to Dr. Limberger's August 26 proposals which recommended the following: 1) Removing the requirement for a 72 hour review of all admissions and the omission of the check list; 2) the establishment of a pilot program of payment to evaluate the effectiveness of paying usual and customary fees under the Medical Assistance Program; and 3) the organization of a representative *ad hoc* committee to review and develop workable Medical Assistance regulations. While the response of the Secretary of Public Welfare was general in nature, it is the feeling of the Reference Committee that such action by the Secretary may represent a more cooperative attitude.

Mr. Speaker, your Reference Committee RECOMMENDS the amending of Resolution 71-6 by deleting the first resolve.

Mr. Speaker, your Reference Committee RECOMMENDS the adoption of Resolution 71-6 as amended.

Your Reference Committee believes that the Pennsylvania Medical Society should pursue with vigor the objectives established by this House of Delegates relative to improvement of the Medical Assistance Program.

We recognize that many of the problems related to the Medical Assistance Program will not be resolved until more favorable fiscal action is taken by the Pennsylvania Legislature.

Mr. Speaker, your Reference Committee RECOMMENDS that the appropriate body of the Pennsylvania Medical Society bring the problems of the Medical Assistance Program to the immediate attention of the leadership of the Pennsylvania Legislature.

Mr. Speaker, I move the adoption of the Report of the Reference Committee on Medical Service A as a whole.

Argonaut Policy No. 1 Presented to Dr. Limberger

At the conclusion of the report of the Reference Committee on Medical Service "A", Dr. Rial announced that A. John Smither, vice president of Parker and Company, Inc. of Pennsylvania, had requested permission to address the House. The former was chief deputy insurance commissioner in the Shafer administration and is now a vice president of the brokerage firm handling the professional liability insurance policy endorsed by the Society.

After noting the fact that as deputy insurance commission he had endorsed the type of medical malpractice insurance program negotiated by the Society with the Argonaut Insurance Company, Mr. Smither went on to report his pleasure in being able to become associated with the program now.

Citing the strong response by members of the Society to the Argonaut-Parker-PMS Program, he urged 100 percent support and presented Argonaut Policy No. 1 to William A. Limberger, M.D., immediate past president of the Society.

Reprints from the Congressional Record, Volume 117, No. 128, containing an article entitled "Health Care in America: a Heretical Diagnosis" by Harry Schwartz, were distributed to the delegates at the request of the Speaker for their information.

Noon Recess and Balloting

The House recessed at 11:45 a.m. for luch and balloting. It was agreed to reconvene at 1:00 p.m. During the noon recess, delegates presented themselves to the Credentials Committee, located in the Ballroom lobby, at which time they received their ballots. Tables were placed immediately to the rear of the Credentials Committee for the convenience of voters, and ballot boxes, nearby, were manned by the tellers. Upon the reconvening of the House at 1:00 p.m., the polls were closed by the Speaker.

Report of the Reference Committee on Governmental Relations

Robert S. Pressman, M.D., Chairman, presented the following report of the Committee, which was adopted as read.

Report of the Council on Governmental Relations *(Official Reports Book - Pages 69-72)*

Mr. Speaker, the Reference Committee has reviewed the Report of the Council on Governmental Relations which, as in previous years, contains information of extreme impor-

tance to medicine in the legislative and general governmental areas.

In reporting back to us on matters referred to them by the 1970 House of Delegates, the Council reports on their deliberation on the matter of countersuit in certain medical malpractice cases where the physician feels that he has been wronged. The report and the comment from legal counsel indicates that the law does not favor countersuit because of harrassment, expense and personal intimidation; and that countersuits brought as part of an original action would be difficult to sustain and be virtually impossible to resolve successfully. Your Reference Committee believes this to be good sound advice and RECOMMENDS that this portion of the report and the memorandum from legal counsel be accepted.

Mr. Speaker we RECOMMEND that this be filed for information.

The Council received a mandate from the 1970 House to contact all of the Society's members and urge their cooperation in contacting members of the Legislature in opposition to Senate Bill 254, a measure to place chiropractors under the Blue Shield program. This was done and the Council reports that the bill was rejected by the Legislature on November 17. In addition, the Council reported to county medical societies on how each of their legislators voted, and notes further that it will continue to do so in the future.

More recently the Council opposed the enactment of House Bill 872, a measure to "eliminate discriminatory provisions of compensation for services and treatment under sickness and accident insurance contracts," which was amended at the last minute in the Senate to include chiropractors. Under this law Blue Shield will probably not be affected. However, since the chiropractors were successful in getting on the measure, they view this as a step toward their ultimate fight to get Blue Shield recognition.

The Council reports on its continuing interest in the termination of chiropractic licensing in Pennsylvania. With this your Reference Committee most wholeheartedly concurs and urges the Council to continue its efforts.

The Council reports its support of legislation at both federal and state levels which would create and sustain family practice departments in medical schools also suggested by previous Houses of Delegates. It also reports on its responsibility for a new Medical Practice Act designed by a Committee of the Board and now ready for introduction into the Legislature. They report on their continued interest in appropriate abortion legislation to conform to the policy suggested by this House after long discussion in 1970. The Council is urged to continue to have the Pennsylvania Department of Public Welfare provide prepaid hospital and medical insurance contracts for all beneficiaries. They also report cooperation with the Secretary of Health, Dr. J. Finton Speller, in having placed in the Department of Health those functions in other departments of State Government which logically and properly, because of their health and medical nature, belong in the Department of Health — all of these items and others mentioned in the report have been urged by this House of Delegates. This House should continue to encourage the Council in these areas.

Mr. Speaker, I move adoption of this portion of the Reference Committee Report.

Perhaps the most vexing problem facing the Council, and, specifically, its Commission on Forensic Medicine, is the matter of contingency fees for attorneys and the problem of discussing with the Bar Association the use of arbitration panels as a solution to the medical malpractice problem. Dr. Rosemond, in his address, echoes concern similar to the Commission on Forensic Medicine in the matter of contingency fees for attorneys. Dr. Rosemond suggests, instead of eliminating the fees, that perhaps the Commission on Forensic Medicine, together with the Bar Association, investigate the "misuse of the contingency fee instead of its elimination," and encourages "lines of communication be kept open with the legal profession." We understand and are sympathetic with the frustration which the Commission members feel; we urge them to continue their work.

Mr. Speaker, I RECOMMEND that this portion of Dr. Rosemond's address be filed and referred to the Commission on Forensic Medicine for information.

The Council reports receiving legislative assignments from the Board of Trustees in the consideration of House Bill 60, the so-called "Voluntary Health Act of 1971," which Act would permit consumer-dominated health service corporations. The bill would circumvent certain provisions in the Blue Shield and Blue Cross Act which guarantee freedom of choice of physicians and hospitals, and prevent providers of service from dominating the boards of the corporations. Following joint Council and Board deliberations, Dr. Limberger forwarded a letter to the Legislature urging that the bill be amended to make it more versatile in its application. Many of these features were added, but others were needed. We urge the Council to continue its efforts.

The House of Delegates of the Pennsylvania Medical Society is on record as favoring experimentation in the delivery and financing of health services which are designed to render the best quality comprehensive health care at the most reasonable cost. Your Committee RECOMMENDS that the House support the Council and the Board of Trustees in its activities concerning House Bill 60.

Mr. Speaker, I RECOMMEND adoption of this portion of the Reference Committee Report.

The Council reports receiving instructions from the Board of Trustees at the request of the Philadelphia Medical Society to support legislation requiring impact-resistant lenses and fire-retardant frames in eyeglasses, to be sold in Pennsylvania. The Council reports that such legislation has passed both Houses and is currently in a conference committee of the House and Senate.

The Council reports on what it considers as a possible breakthrough in the area of Medical Examiner Systems in its report, and, hopefully, their optimism will be well founded — if successful, Medical Examiners will be permitted to be appointed by counties or groups of counties under the "Optional Forms of County Government Law" currently working its way through the State Legislature.

Finally, the Council reports its conduct of a successful Congressional visitation in which over thirty physicians, State Society staff, and county society executive secretaries went again to meet with their Congressmen and United

States Senators. It is noteworthy that the Congressmen do not expect a national health insurance program in this session of Congress and that they feel that the greatest need is in the area of catastrophic health coverage. They feel that it probably can be added to existing legislation. Your Committee commends the Council on these visitations and recommends their being continued.

Mr. Speaker, I RECOMMEND adoption of this portion of the Reference Committee Report.

Supplementary Report of the Council on Governmental Relations *(Appendix H)*

The Council has submitted, as it promised it would do, a Supplemental Report solely on legislation currently being considered by the Pennsylvania General Assembly, in which the Society has an interest. We strongly commend it for your reading and suggest that it is an excellent report for Delegates to use to transmit to their county medical societies following the session of the House. It should be pointed out that final action on all of these bills will not be able to be reported until next year when the Legislature adjourns.

The Committee received testimony from representatives of the Pennsylvania Psychiatric Society concerning House Bills 1145 and 1184. The first measure would eliminate the office of the Commissioner of Mental Health and the requirement that he be a qualified psychiatrist. The second measure removes from state law the requirement that directors of state mental facilities be physicians. We urge the House of Delegates to reaffirm the Society's long-standing opposition to such legislation.

Mr. Speaker, I move the adoption of this portion of the Reference Committee Report.

Address of the President - Portion on The "Legislative Field" (November Pennsylvania Medicine)

Dr. Limberger, in his address to the House, spent several minutes in discussing with us his impressions of problems that the Society's legislative program faces in view of the other priorities before the General Assembly. It is a good capsulization of what is happening and we can recommend it to you in reporting the legislative area to your county medical societies.

Mr. Speaker, I move adoption of this portion of the Reference Committee Report.

Revision of Certificate of Death - Resolution 71-8 *(Official Reports Book, Page 136)*

Introduced by: Joseph V. Caliguiri, M.D.
in behalf of the Allegheny County Medical Society

Author: Ralph J. Stalter, M.D.

WHEREAS, The Certificate of Death currently used by the State of Pennsylvania is generally conceded to contain a number of serious imperfections from both the statistical and administrative standpoints; and

WHEREAS, The format of the aforementioned Certificate of Death also has major shortcomings; and

WHEREAS, for the above reasons, the Medical Examiner's office of the County of Philadelphia effected major changes in the Certificate of Death of the State of Pennsylvania shortly after the County was granted its Home Rule Charter in 1955, which Certificate then replaced the Certificate of Death in the State of Pennsylvania in that municipality; and

WHEREAS, The Certificate of Death used by the County of Philadelphia has essentially the same composition as the standard Certificate of Death, promulgated by the U.S. Department of Health; and

WHEREAS, It is highly desirable, from an epidemiologic and statistical standpoint, to simplify and standardize the data-gathering and record-keeping process as much as possible; therefore be it

RESOLVED, That the Pennsylvania Medical Society take whatever action it deems appropriate to bring about such revision of the current Certificate of Death in the State of Pennsylvania as is necessary to bring it into conformity with the Standard Certificate of Death proposed by the U.S. Public Health Department at the time it last revised that Certificate (1968).

Your Reference Committee feels that this is a worthwhile procedure and urges support of this Resolution revising the current Certificate of Death in the State of Pennsylvania to bring it into conformity with the standard certificates of death adopted by the United States Public Health Service. The Committee would call the House's attention to the fourth "Whereas" which testimony showed was incorrect, but, since we are only recommending adoption of the final "Resolve" we, accordingly, recommend that Resolution No. 71-8 be approved.

Mr. Speaker, I RECOMMEND adoption of Resolution 71-8.

Objectionable Conditions in Boarding Homes for Elderly Citizens - Resolution 71-9 *(Official Reports Book, Page 136)*

Introduced by: Joseph V. Caliguiri, M.D.
in behalf of the Allegheny County Medical Society

Author: Leonard E. Egerman, M.D.

WHEREAS, The Geriatrics and Chronic Disease Committee of the Allegheny County Medical Society has been informed that there are shocking and deplorable boarding home situations which many older people must tolerate because there are not alternative living arrangements available to them and thus are at the mercy of designing persons; and

WHEREAS, These situations are said to involve unfit, dangerous and objectionable living conditions including overcrowding, fire hazards and inadequate dietary, medical and social services; and

WHEREAS, the Allegheny County Medical Society Board of Directors has been made aware of this situation, and the Geriatrics and Chronic Disease Committee has pledged to support community efforts to improve these conditions by taking an active part in involving the Allegheny County Medical Society and its members in every proper

endeavor to improve the medical, social, environmental and protective legal circumstances of the aging population, so that this important segment of our society, including many of us, may live with greater dignity and enjoy the respect earned throughout their lives; therefore be it

RESOLVED, That this information be transmitted to the House of Delegates of the Pennsylvania Medical Society so that appropriate measures including legislative action can be taken to correct this inhuman situation.

Your Committee feels that every effort must be made continually to improve the living conditions of all citizens of our Commonwealth. Although there is probably sufficient authority in the Department of Public Welfare and the Department of Health to encompass this, it appears to be worthwhile for this House of Delegates to lend whatever assistance it can to correct situations that are inimical to the health and well-being of our senior citizens. However, the Resolved portion of the Resolution is unclear, as was brought out in testimony, and so we recommend that the Resolve read as follows:

> *RESOLVED, that any information concerning objectionable conditions in Boarding Homes for elderly citizens be transmitted to the Board of Trustees of the Pennsylvania Medical Society so that appropriate measures may be taken to correct this inhuman situation. We urge executive and legislative action as deemed necessary. This should include licensing and inspection.*

Mr. Speaker, I RECOMMEND adoption of substitute Resolution 71-9.

Resolution No. 71-12: State Committee on Quackery

Introduced by: Frank J. DiLeo, M.D.,
in behalf of the Lehigh County
Medical Society

Author: Stephen J. Barrett, M.D.

WHEREAS, Chiropractors continue to make political gains in spite of the fact that what they do is without scientific foundation; and

WHEREAS, To date, the medical profession in Pennsylvania has adopted a primarily defensive position; therefore be it

RESOLVED, That the Pennsylvania Medical Society create a Committee on Quackery with an annual operating budget of at least $50,000; and be it further

RESOLVED, That the Pennsylvania Medical Society endorse and publicize in every available way the flier program of the Lehigh Valley Committee Against Health Fraud, Inc.

This Resolution, which would appropriate $50,000 to the creation of such a committee, seems to have a laudatory purpose. The Committee feels that it cannot support the budgetary item since it would place an inappropriate strain on the already overstrained budget. Your Committee also observes that the Resolution directs itself to chiropractic exclusively, and this is only one facet of the quackery problem. The program of the Lehigh Valley Committee is unfamiliar to us and we feel this material should be studied for its application, and so we recommend that the "Resolved" portions of Resolution No. 71-12 be deleted and the following adopted:

> *"RESOLVED, that the Board of Trustees of the Pennsylvania Medical Society consider creating a separate organization to consist of physicians and laymen; and be it further*
>
> *RESOLVED, that this organization explore the public relations value of the flier program of the Lehigh Valley Committee against Health Fraud; and be it further*
>
> *RESOLVED, that if such organization deems it appropriate that it undertake an educational program throughout the state to the end that all citizens learn what constitutes health quackery."*

Mr. Speaker, I RECOMMEND adoption of substitute Resolution 71-12.

Address of the President - Portion on Emergency Medical and Health Services in Pennsylvania

Your Reference Committee was pleased to learn of the work done by the Commission on Emergency Medical Services of the Society in the writing and publishing of the "White Paper" on Emergency Medical and Health Services. It also notes with enthusiasm the number of copies that were distributed to important county, municipal and state officials. It is further pleased to learn of the interest that it has evoked on the part of these officials and commends the Commission for its work.

Mr. Speaker, I RECOMMEND the adoption of this portion of the Reference Committee Report.

Report of the Reference Committee on Medical Service "B"

Ulysses E. Watson, M.D., Chairman, presented the report of the Committee, which was adopted as read.

Supplemental Report "B" of the Council on Medical Service and *(Official Reports Book - Pages 104-133)*

Recommendation of President *(Address of President-November* Pennsylvania Medicine*)*

Recommendation of President-Elect (Address of President-Elect - November Pennsylvania Medicine*)*

The members of the Reference Committee were pleased that, due to foresight of the Speaker of the House, the open hearing of the Reference Committee was scheduled so that all interested Delegates could attend and participate. The Reference Committee was impressed with the interest and constructive concern expressed by a large contingent of the House of Delegates. The Reference Committee was pleased to note the wide acceptance of the general objectives outlined in the Council's Supplemental Report "B".

Your Reference Committee believes that the objectives and activities set forth in the Supplemental Report are consistent with the action of the 1970 House of Delegates

directing the Council on Medical Service to consider the development of a health care financing and delivery mechanism which will serve as a viable alternative to present and proposed methods. We wish to commend the Council, its Subcommittee, and staff for an outstanding performance in developing the report.

Your Reference Committee noted that there was general approval of the concept of peer review and support of the Research Plan of the PMS - Medical Care Appraisal Project as outlined on Pages 106 through 115. The Council is to be commended for not only developing the Plan but for also obtaining, from other sources, the funds for its support. In developing the objectives of the Research Plan, your Reference Committee urges physicians in all specialties, including family physicians, to participate in the development of criteria for medical care appraisal.

Much of the discussion before the Reference Committee reflected interest, concern, confusion, misunderstanding, and enthusiastic support of the concept of the Pennsylvania Medical Care Foundation. The overall tenor of the testimony was in support of the objectives of the Medical Care Foundation.

Based on this testimony, your Reference Committee recognizes the need for the development of further details of the operational aspect of the Foundation. In particular, the Reference Committee reviewed the draft (Appendix K) of the Bylaws of the Pennsylvania Medical Care Foundation. Your Reference Committee feels that the Council should further refine the draft of the Bylaws in consultation with county medical societies, hospital medical staffs, and other participating and cooperating agencies.

In pursuing the development of the operational structure and organizational relationships of the Medical Care Foundation, the Council on Medical Service should be urged to continue the development and expansion of cooperative relationships with hospitals, governmental agencies, third parties, and public representatives.

Your Reference Committee was impressed with the significance of the proposed Program and its long-range implications. Your Reference Committee urges the Council to proceed, without delay, with the activities of the Medical Care Appraisal Project and the further development of the Pennsylvania Medical Care Foundation.

In conclusion, your Reference Committee believes that the concept of the Pennsylvania Medical Care Foundation is indeed sound and that such a Foundation will have a salutary effect upon the development of a high quality pluralistic system of medical care delivery.

Mr. Speaker, in accordance with this belief, your Reference Committee RECOMMENDS adoption of this report and Supplemental Report "B" of the Council on Medical Service.

Annual Assessment

David S. Masland, M.D., Chairman of the Finance Committee of the Board of Trustees and Councilors, presented the following report, which was adopted by the House, thereby establishing the annual assessment for 1972 at $100.

Mr. Speaker, Members of the House of Delegates, the Finance Committee RECOMMENDS that the 1972 annual assessment for active members of the Pennsylvania Medical Society be $100.

Contingent upon the approval by the House of the 1972 assessment, the Finance Committee plans to introduce a resolution before the Board of Trustees which will recommend that 8 percent of the annual assessment be allocated to the Educational Fund of the Educational and Scientific Trust of the Pennsylvania Medical Society, which, in the case of full dues-paying members will amount to $8.00.

The Finance Committee also plans to recommend to the Board of Trustees that of the annual assessment paid by each active member, 1 percent, or in the case of full dues-paying members $1.00, be allocated to the Medical Benevolence Fund. This means that rather than $100, a total of $91 of the annual assessment of each full dues-paying member will be available to the General Fund for operating expenses of the Society.

New Business

Motion: It was moved and seconded that the Committee on Hotel and Local Arrangements be commended for its work in connection with the 1971 Annual Session. Motion carried.

Motion: It was moved and seconded that the Allegheny County Medical Society be thanked for its reception tendered to delegates at its new headquarters building on October 4. Motion carried.

Motion: It was moved and seconded that the House give a vote of thanks to the Speaker and the Vice Speaker for the manner in which they conducted the meeting. Motion carried.

The meeting adjourned at 1:30 p.m.

Respectfully submitted,
William Y. Rial, M.D., Speaker
John B. Lovette, M.D., Vice Speaker
Raymond G. Grandon, M.D., Secretary
Robert L. Lamb, Assistant Secretary

Appendices

Appendix A
1971 PaMPAC Report to the House of Delegates
William B. West, M.D., Chairman

Mr. Speaker, Mr. President, Mr. President-Elect, Members of the House, distinguished guests, I appreciate this opportunity to present the Annual Report of the Pennsylvania Medical Political Action Committee.

The political action movement within the medical profession is just about to complete its first decade. It is extremely important at this time in our existence that we carefully reexamine our successes and our failures so that we can accomplish the legislative result we are all working toward.

When I reported to you last year at Annual Session, we were less than one month away from the November election. In 1970, PaMPAC was involved in 94 election contests. Of

the 94 candidates supported, 80 have been elected or re-elected, with many representatives being placed on key committees that handle health legislation.

Since 1971 was labelled an "off" election year, PaMPAC focused its attention to membership. Traditionally, PAC membership usually drops a little from its previous election year. Through direct mail solicitation and a follow-up mailing to the non-PAC physicians in Pennsylvania, membership in PaMPAC has increased 10% from the 1970 figure.

Joint billing continues to be the most efficient and effective way to collect voluntary PAC membership contributions. However, we recognize that joint billing does not do the whole job. It does not teach the newcomer in the medical community the value of membership in the PAC movement. Therefore, we have continued to seek out the non-member and have made personal appeals for his participation. Throughout the year, our staff and Board members have had the opportunity to explain the activities of PaMPAC at many of the county medical society meetings. Since the political scene changes on a day-to-day basis, it is most important that we continue this political education at the grass roots level. We recognize that there are still some misconceptions and questions about PaMPAC, and we would like to discuss these matters with the component societies at any time.

Through the cooperation of the Woman's Auxiliary to the Pennsylvania Medical Society, the topics of political action and legislation have been included on the agenda of their regional workshops. Voter registration drives and candidate support activity are subjects that are being covered at these meetings.

We can all mark certain years of our lives as a critical time. Usually we do this in retrospect. Rarely are we able to recognize these years as critical while we are busy living them. In 1972, we will be once more called upon to select and elect the governing bodies that will be responsible for designing the method of delivery of health care. And so membership is, again of necessity, our first priority in any year— on year, or off. But our second priority, the success of which is conditional upon the first, is candidate support. Local physician involvement and participation will be the only way we can achieve this task.

The first step toward obtaining this goal is evaluating the candidates and their campaigns. Yesterday's lessons prepare us well for this. The second step is acting on this evaluation. Supporting friendly incumbents is an immediate and necessary task in which our profession can excel. It is most difficult, however, to find a challenger for an "unfriendly" incumbent, but it can be done, and done well. In some instances of unfriendly incumbents, perhaps medical personnel should be enlisted to run for the Legislature. We are badly in need of more physicians in the legislative halls.

Yes, redistricting will be a problem in 1972 and, yes, boundary lines will change. Yes, political alliances will be upset and old political ties will be broken. But, congressional and state reapportionment must not be used as a reason or an excuse for postponing action to support candidates. We must start now in searching out the talent at the grass roots and put fresh new minds to work in helping to elect our representatives.

When President Nixon addressed the AMA House of Delegates this June, he said, "I know many of you are so concerned whenever anybody suggests that you get into politics, and I do not speak in any partisan sense. I am not concerned about whether you are in politics in one party or the other. The main thing is to be in. I have heard a doctor say on occasion 'I am only interested in my profession; I am not interested in politics.' Let me tell you something: He better get interested in politics or he won't have a profession to be interested in."

Finally, Mr. Speaker, let me reaffirm, in behalf of PaMPAC, our gratitude to the Pennsylvania Medical Society and its component societies for their continuing support.

Appendix B
Referrals — Address of Dr. Limberger
October 4, 1971

Reference Committee on Reports of Officers
- Address in general
- Comments and recommendation concerning PaMPAC
- Comments and recommendation concerning membership

Reference Committee on Medical Service B
- Comments and recommendation concerning Pennsylvania Medical Care Foundation

Appendix C
Referrals — Address of Dr. Rosemond
October 4, 1971

Reference Committee on Reports of Officers
- Comments and recommendation concerning dollar priorities
- Comments and recommendation concerning PaMPAC billing

Reference Committee on Medical Service B
- Comments and recommendation concerning Medical Care Foundation

Reference Committee on Education and Science
- Comments and recommendation concerning Continuing Education Institute

Reference Committee on Constitution and Bylaws
- Comments and recommendation concerning continuing education membership requirements
- Comments and recommendation concerning medical student membership

Reference Committee on Governmental Relations
- Comments and recommendation concerning contingency fees

Reference Committee on Reports of Standing and Special Committees
- Comments and recommendation concerning activity of censors

Reference Committee on Public Service
- Comments and recommendation concerning medical service distribution

Appendix D
Supplemental Report — AMA Delegation

Eleven Pennsylvania Delegates were seated at the 120th Annual Meeting of the American Medical Association held in Atlantic City, New Jersey, June 20-24, 1971, as follows: Drs. William A. Barrett, Samuel B. Hadden, Park M. Horton, Edmund L. Housel, William A. Limberger, John B.

Lovette, Malcolm W. Miller, William Y. Rial, Russell B. Roth, William B. West. Dr. Wilbur E. Flannery served as delegate in place of Dr. Wendell B. Gordon.

Alternate delegates in attendance were: Drs. R. Wm. Alexander, Robert F. Beckley, Jerome Chamovitz, Leo C. Eddinger, Paul S. Friedman, Raymond C. Grandon, Matthew Marshall, Jr., David S. Masland, George A. Rowland, and R. Robert Tyson. In addition, Dr. Mayer A. Green of Pittsburgh, delegate from the Section on Allergy, and Dr. John H. Moyer of Philadelphia, alternate from the Section on Clinical Pharmacology and Therapeutics, sat and worked with the Delegation.

Undoubtedly, the highlight of the meeting was President Richard M. Nixon's address to the House of Delegates on Tuesday, June 22.

Three resolutions were introduced by the Pennsylvania Delegation as follows:

(1) Subject: "Use of Safety and Impact Resistant Materials in Eyeglasses"— "Resolved, That the American Medical Association recommends that all goggles, spectacles, sport and sunglass lenses be of safety or increased impact resistant material unless specifically ordered otherwise by the prescribing physicians; and be it further Resolved, That all frames should be of fire retardant construction and constructed of posterior retaining design."

In its report, the reference committee noted that the Food and Drug Administration has issued a statement of policy requiring that after December 31, 1971, all eyeglasses, including sunglasses, must be fitted with impact-resistant lenses except when the physician finds that such lenses will not fulfill the visual requirements of a particular patient, and recommended the adoption of the resolution. The House referred the resolution to the Board of Trustees and AMA Legal Department for report back to the House.

(2) Subject: "Extension of the Appeal Period to the Judicial Council of the AMA"— "Resolved, That the appeal period to the Judicial Council of the AMA be extended from thirty (30) days to sixty (60) days through the following amendment: BYLAWS - CHAPTER IV - DISCIPLINARY ACTION, Section 1. Regular and Associate members "(A) In all controversies between a member and his component society or state association, an appeal may be made to the Judicial Council on questions of law and procedure only, but not of fact. Notice of appeal shall be filed with the Judicial Council within [thirty (30)] *sixty (60)* days of the date of the decision by the state association, and the appeal shall be perfected within sixty (60) days thereof; provided, however, that the Judicial Council, for what it considers good and sufficient cause, may grant an additional thirty (30) days for perfecting the appeal."

The Reference Committee was not convinced of any need to extend the time for filing a Notice of Appeal, which commences with the date of the state association's decision, and pointed out that an additional 60 days is presently provided for perfecting the appeal, so only the time for filing the initial "Notice of Appeal" is in question. The Reference Committee recommended rejection of the Resolution and the House concurred.

(3) Subject: "New Classification of Membership"— "Resolved, That the American Medical Association consider creating a Senior Active membership category with full benefits which would provide for 50% payment of the annual dues for any physician who reaches age 65 and has had at least 30 years of continuous AMA membership."

The Reference Committee was of the opinion that the resolution would have the effect of reducing AMA income without any corresponding reduction in AMA expenditures and reminded the House that the Bylaws presently provide for a waiver of dues for members in financial hardship and for members over 70 years of age. See Chapter III of the AMA Bylaws. The Reference Committee recommended rejection of the Resolution and the House concurred.

Pennsylvania continues to maintain physicians in key positions of the AMA. Dr. Russell B. Roth was unanimously elected Speaker of the House of Delegates for a third term; Dr. Elmer G. Shelley, a Past President of the Pennsylvania Medical Society, continues as Chairman of the AMA Judicial Council; Dr. William A. Sodeman of Philadelphia, is Chairman of the Council on Medical Education and Dr. M. Louise C. Gloeckner continues to serve as a member of the Council on Constitution and Bylaws.

Dr. Park M. Horton was elected Chairman of the Delegation and Dr. Malcolm W. Miller was elected Vice Chairman. Dr. Edmund L. Housel continues to serve as Secretary of the Delegation.

Appendix E
Supplemental Report A
Board of Trustees and Councilors

At its August, 1971 meeting the Board of Trustees took action on a number of items which are of interest to the members of the House of Delegates, but which require no specific action. The Board of Trustees takes this opportunity to inform the House of Delegates of some of the major actions taken at that meeting.

1. Determined to recognize the 100th anniversary of the Warren County Medical Society and that such recognition be coordinated through Dr. Keck.

2. Approved sponsorship of the Reception preceding the State Dinner, Tuesday evening, October 5, 1971 at the Pittsburgh Hilton, by Parker and Company, Inc. of Pennsylvania and the Argonaut Insurance Company.

3. Authorized the Special Board Committee on Susquehanna Valley Regional Medical Program to appoint a search committee for the purpose of recruiting a physician to direct the program.

4. Authorized a $30,000 contribution for the year 1971-72 (the Foundation's fiscal year) to the Pennsylvania Medical Care Foundation with $15,000 for the first six months' operations coming out of the general fund for 1971 and $15,000 for the first six months of 1972 to come from 1972 funds.

5. Determined to submit to the Governor a new list of physicians acceptable to the Society for appointment to the State Board of Medical Education and Licensure.

6. Directed that a letter be written to the Regional Advisory Group stating that the Board supports the activities and plans of the Susquehanna Valley Regional Medical Program.

7. Determined to urge state government to examine the noise levels of specific products and set operational noise levels which the manufacturer will be required to clearly label on each item before the product may be sold in Pennsylvania.

8. Determined to oppose House Bill No. 1145 which abolishes the office of Commissioner of Mental Health.

9. Determined to accredit continuing medical education programs in Pennsylvania with implementation to be carried out by the Council on Education and Science in consultation with the AMA.

10. Established an Environmental Improvement Recognition Award to be made available to individuals, corporations, voluntary groups, and/or communities for efforts to improve the environment, such an award program to be administered by the Council on Education and Science.

11. Recognized Richard B. Magee, M.D., Chairman of the Council on Education and Science, for his many contributions to the educational and scientific activities of the Society over the past six years.

12. Supported in principle a recommendation calling for a universal health insurance program similar to "workmen's compensation." Implementation is to await development of the Society's Foundation.

13. Approved an Excess Major Medical Insurance Coverage Program for members to be underwritten by the Lumbermens Mutual Insurance Company and administered by the Bertholon-Rowland Agencies.

14. Amended and approved the "Kelly Committee" draft of the Medical Practice Act of 1971 dated July 28, 1971 and authorized its introduction to the legislature.

Appendix F
Supplemental Report A
Council on Medical Service

The following report outlines recent developments related to Pennsylvania Blue Shield and is being submitted for the consideration of the House of Delegates as a supplement to the Annual Report of the Council on Medical Service:

In December of 1970, the Council's Subcommittee to Advise Blue Shield considered several problems related to the inequities and inconsistencies in Blue Shield Fee Schedule Programs. Blue Shield representatives met with the Subcommittee and the Council to explain the many problems involved in up-grading fee schedule allowances and income limitations in view of the desire to preserve the Prevailing Fee Program.

Based on the Council's recommendation, the PMS Board of Trustees took action at its January, 1971 meeting to urge Blue Shield to continue efforts to evaluate the inequities and inconsistencies in the Plan B Fee Schedule and to report the conclusions of their studies to the Council.

At its April, 1971 meeting, the Subcommittee to Advise Blue Shield was informed by Blue Shield representatives that Blue Shield's Fee Schedule Committee recommended a revision of Plan B. However, the Blue Shield Board of Directors had referred the matter to a special Study and Planning Committee which then recommended that, rather than changing Plan B, a new fee schedule plan with higher income limits be developed. This recommendation was approved by the Blue Shield Board of Directors on May 5, 1971.

As a result, at the August 4, 1971 meeting of the Blue Shield Board of Directors, the Fee Schedule Committee, with the assistance of Blue Shield management, presented a proposed Plan C which outlined the following general provisions:

1. Proposed fee allowances, along with the methodology used to develop such allowances;
2. A program of benefits similar in scope to that available under the Prevailing Fee Program; and
3. Income limits for service benefits.

After reviewing the report of the Fee Schedule Committee, the Blue Shield Board of Directors recommended that the fee allowances of the proposed Plan C be referred to the appropriate PMS Specialty Advisory Committees for review and comment.

After receiving the Blue Shield request for review, it did not seem appropriate to refer the proposed Plan C fee allowances to the Specialty Advisory Committees since it appeared the offering of a new fee schedule program by Blue Shield may be in conflict with present Society policy, which supports the Prevailing Fee concept and urges the eventual elimination of fee schedule plans. Therefore, Blue Shield representatives met with the Council on August 22, 1971 to discuss the development of the proposed Plan C Fee Schedule Program. The Blue Shield representatives brought the following points to the attention of the Council to support the introduction of the proposed Plan C:

1. Since Blue Shield introduced its Prevailing Fee Program on August 1, 1965, enrollment thereunder has increased steadily but not at a phenomenal rate. As of May 31, 1971, there were 1,692,437 persons (29% of the total Blue Shield enrollment) enrolled under the Prevailing Fee Program.
2. Enrollment under Plan A has continued to decline markedly as a result of Blue Shield's efforts to have subscribers upgrade to Prevailing Fee or Plan B. As of May 31, 1971, there were 329,543 persons enrolled under Plan A - a drop from 925,506 in 1967 when the PMS House of Delegates asked Blue Shield to encourage Plan A subscribers to change to better programs.
3. Enrollment under Plan B has continued to decline but only slowly. As of May 31, 1971, there were still 3,235,264 persons enrolled thereunder, or 55% of the total Blue Shield enrollment.
4. The upgrading of subscribers' coverage from Plan B to Prevailing Fee has been the slowest in those areas where the Prevailing Fee rates have been highest. For example, because of the different economic characteristics of various parts of our state, the Prevailing Fee monthly group rate for a family in the Allentown area is $8.55; in the Wilkes-Barre area, $8.70; and in Philadelphia, $11.70. Consequently, in those areas such as Philadelphia where the sale of the Prevailing Fee Pro-

gram has been the slowest and thus not widely available, the doctors have been urging Blue Shield to improve Plan B allowances and some of the subscribers (including large purchasers) have been clamoring for an option that is better than Plan B but less than Prevailing Fee.

5. The matter of improving Plan B was studied by the Blue Shield Special Study and Planning Committee comprised of the members of the Corporate Planning Committee of Blue Shield's Board and of the Steering Committee of Blue Shield's Subscriber Advisory Council. It was concluded that:

a. Marketing efforts should continue to be concentrated primarily on the promotion of Prevailing Fee programs.

b. A new Plan C should be introduced as an option that is an improvement on Plan B but less than Prevailing Fee. It was felt that it would be easier to obtain the approval of the Insurance Department of a new Plan C rather than an improvement of the current Plan B. It would mean filing a "new product" rather than a request for a rate increase. (In effect, any attempt to improve the current Plan B allowances would also require Blue Shield to improve the current Plan B income levels for service benefits. Thus Blue Shield ends up in the same place as a "new Plan C".)

6. In view of the foregoing, the proposed "Plan C" allowances, unlike the Plan A and B allowances when they were established, do not represent the present "going rate" for doctors' charges; the Prevailing Fee program has been designed to do that. If the PMS Specialty Advisory Committees should recommend, upon their reviews, that the proposed allowances be increased to any considerable extent, then the increases would conceivably result in premium rates which would be higher than those for Prevailing Fee and which would defeat the purpose of introducing an option that represents an improvement over Plan B and that could be made available in the market place in the event certain segments of the public could not afford the price of Prevailing Fee.

7. The proposed "Plan C" allowances should not be regarded as being fixed for a long period of time in the future. It is the intent to include in the filing, if and when it is made, a provision to permit adjustment in allowances in the light of cost-of-living index. The timing of such periodic adjustments has not been determined.

8. The current situation in which Blue Shield finds itself is this:

a. Because of Blue Shield's mounting underwriting losses, it will have to seek various rate increases, one of which will be for Plan B even if no action is taken to improve the allowances.

b. A filing of a new Plan C as a "new product", properly rated, would have a much better chance of being approved by the Insurance Department. It would also help provide against underwriting losses.

c. For reasons cited in Paragraph 6, the Plan C cannot possibly satisfy the members of the professions in certain areas to the degree that they had in mind when they began to urge Blue Shield to improve Plan B.

d. The professions can well raise the point: If a new Plan C is launched, then Plan B as it currently exists "will still be around" while marketing efforts are made to convert subscribers to Prevailing Fee; and if not that, at least to Plan C. That will be true. However, Blue Shield would be in a better position to convince the Insurance Department to permit the elimination of Plan A and let Plan B remain as the lowest Fee Schedule Plan.

During the discussion, the Council made the following points to the Blue Shield representatives:

1. The present policy of the Pennsylvania Medical Society strongly supports the Prevailing Fee concept and urges the ultimate elimination of all Fee Schedule Programs offered by Blue Shield.

2. The offering of an additional Fee Schedule Program will tend to retard the enrollment of subscribers in the Prevailing Fee Program, particularly in the major metropolitan areas of the state, and may have a serious adverse effect on the future of the Prevailing Fee Program.

3. The recommendation of the Pennsylvania Medical Society to revise Plan B was not intended to support the development of an additional Fee Schedule Program, but rather to improve the inequities and inconsistencies in the present Plan B Fee Schedule allowances.

4. The Council felt that since Blue Shield anticipates requesting approval of the Insurance Department for a rate increase for Plan B, it (Blue Shield) could, at the same time, request approval for other recommended revisions in the Plan B Program.

5. The Council recognized that certain subscriber groups do not feel the Plan B Fee Schedule allowances or income limits are adequate while, at the same time, these groups do not support the concept of usual, customary, and reasonable fees under the Prevailing Fee Program. It was noted that if, after revision, Plan B is still not acceptable to these groups, they would still have the option of purchasing the Prevailing Fee Plan or consider other health insurance programs since the Council did not feel it is essential that Blue Shield enroll *all* potential subscribers.

6. The Council agreed that the methodology proposed by Blue Shield to develop the fee schedule allowances for the proposed Plan C would also be acceptable as a reasonable approach to the revision of Plan B Fee Schedule allowances.

The Council concluded that the limited advantages of offering a new fee schedule program would not offset the adverse effects an additional plan would have on the Prevailing Fee Program. The Council also agreed that the Pennsylvania Medical Society has a responsibility to inform its membership of the ultimate policy adopted.

Council Recommendation

The Council on Medical Service recommends that the House of Delegates reiterate its support of the Prevailing Fee concept and urge Pennsylvania Blue Shield to continue to actively market the Prevailing Fee Program. The Council

also recommends that Blue Shield continue its original efforts to revise Plan B (in lieu of offering the proposed Plan C) in accordance with previous recommendations approved by the Council and the PMS Board of Trustees.

Appendix G
Supplemental Report B
Council on Medical Service
Medical Care Foundation Summary

During 1969 the Pennsylvania Medical Society's Council on Medical Service recognized the probable development of some type of legislation to control health care costs, particularly hospitalization premiums. The Council also was aware of pending federal subsidies to promote the development of prepaid (capitation) group practice on a more extensive basis as an alternative to present mechanisms of financing and delivering health care. The Council concluded that, while the Pennsylvania Medical Society had been reasonably effective in developing programs to assure proper use of health care dollars, it was apparent that the developing problems of financing health care would require an innovative statewide effort to meet the challenge. The Council agreed that, in view of the increased state and federal legislative efforts, there is a pressing need to develop a more effective mechanism by which practitioners can collectively influence the planning of health care financing and delivery systems.

The Council felt a statewide Medical Care Foundation would be the best mechanism to achieve this objective. The 1970 PMS House of Delegates concurred with the Council's conclusions and approved, in principle, the concept of the Pennsylvania Medical Care Foundation.

One of the primary functions of the Pennsylvania Medical Care Foundation will be to develop statewide systems, with regional variations, necessary to carry out medical audit, utilization review, and claims processing procedures. The Research and Development phase for organizing the Pennsylvania Medical Care Foundation will be carried out by the PMS - Medical Care Appraisal Project which was approved in July of 1971 by the U.S. Department of HEW's National Center for Health Services Research and Development. The primary purpose of the Medical Care Appraisal Project is to develop the procedures necessary for providing an alternative means of financing and delivering quality health care at a cost reasonable to both the consumer and the provider.

In order to achieve this basic objective, the Project will develop comprehensive prospective and retrospective computer claim processing and utilization review systems utilizing the resources of the Pennsylvania Medical Society, Blue Shield, Blue Cross, and the Hospital Utilization Project (HUP). Following the developmental phase, the operational phase will be implemented by adapting the systems to the health service plans offered to consumers by the Pennsylvania Medical Care Foundation on a dual choice basis as an alternative to present delivery and financing methods.

The systems will be designed to: (1) develop the Pennsylvania Medical Care Foundation as an alternative health care financing mechanism for the option of the public; (2) qualify the Pennsylvania Medical Care Foundation as an agency to take leadership in developing a Professional Standards Review Organization (PSRO) and a Health Maintenance Organization (HMO); (3) provide the Pennsylvania Medical Society with adequate resources to assist the Blues and the private health insurance industry in developing more appropriate cost control mechanisms; (4) encourage hospital medical staffs to develop more effective medical audit programs for the benefit of all patients, including those who do not enroll in the Foundation Program. The Program is intended to complement and assist in the development of the post-graduate medical education programs sponsored and/or coordinated by the Pennsylvania Medical Continuing Education Institute by identifying situations where the application of medical knowledge might be improved.

The prospective or prepayment claim processing systems and retrospective utilization review systems developed by the PMS - Medical Care Appraisal Project (MCAP) will be adapted to the Foundation health care plans and utilized as both quality and cost control mechanisms. In order to achieve the objectives of the Medical Care Foundation, it will be necessary to modify and extend present claim processing, utilization review, and medical audit procedures for both inpatient and ambulatory services. The claim processing system will be designed to identify individual claims which deviate from established PMS criteria. The utilization review system will be designed to identify deviations in patterns of care, utilization by institutions or individual physicians, and potential deficiencies in medical education.

The systems are intended to provide effective quality and cost controls, reducing both the bureaucratic interference with medical practice and the administrative red tape for reimbursement to physicians and hospitals and to provide a basis for more effective post-graduate medical education programs. Physicians who agree to participate in the Foundation Program will have freedom of choice of type of practice (solo, group, closed panel group) and method of reimbursement (fee-for-service, salary, or capitation).

The activities of the Pennsylvania Medical Care Foundation will be governed by a Board of Directors which will be elected by the Pennsylvania Medical Society's House of Delegates. It will be made up of practicing physicians, representatives of cooperating organizations, and public representatives. The Research Plan of the Medical Care Appraisal Project was submitted to the 1971 PMS House of Delegates and approved. The details of the operational format of the Pennsylvania Medical Care Foundation will be developed for presentation at the 1972 meeting of the House of Delegates.

Appendix H
Supplemental Report
Council on Governmental Relations

As we promised in the Annual Report which was filed earlier in the year — "We will, prior to the October session of the House, submit a supplementary report on all of the legislation of interest to us." Accordingly there is a list attached of those bills which have been studied by the Council and forwarded to the Board of Trustees. The list, as you can see, contains the bill number, an explanation of the bill, the Society's position, and, finally, the position of the bill as it is now in the legislative process. These measures should not be foreign to you since the Council forwards its Legislative Bulletin to county societies on a weekly basis.

The Bulletin reports up-to-date information on all of these measures routinely.

At this writing the Legislature is in recess until October 4, unless sooner recalled by the presiding officers or the Governor for a special purpose. After an eight months' struggle to design a budget for the Commonwealth and to tailor a tax and revenue-raising program to pay for it, they are taking a breather. This quest for money has been their almost exclusive problem. Very little has been accomplished in the general health and welfare area which is our major area of interest.

When the Legislature returns, it must give almost immediate attention to Congressional reapportionment and items mandated by the 1968 Constitutional Convention, and, then, hopefully, to many of the items of interest to Medicine.

Legislation of Interest to the Pennsylvania Medical Society
In the Pennsylvania Legislature
September 1971

Bill No.	Explanation	Society's Position	Legislative Position
	Abortion		
S-617	Would permit abortions up to sixteen weeks under limited and specific circumstances, i.e., death of mother a distinct possibility; pregnancy caused by rape or incest	Oppose	Referred to Senate Rules Committee
H-536	Any woman has the *right* to an abortion up to sixteen weeks of pregnancy in an accredited hospital or medical facility, not requiring any doctor or hospital to carry out an abortion against its or his will	Oppose	Re-referred to House Committee on Health and Welfare
H-800	Would declare that all abortions under any circumstances are illegal	Oppose	Referred to House Committee on Health and Welfare
S-928	Would repeal those portions of the Penal Code referred to as the "Abortion Law"	Under study	Referred to Senate Judiciary Committee
	Advertising		
H-526	Prohibiting persons licensed to practice any "healing art" to solicit patients or advertise services	Support	Referred to House Committee on Professional Licensure
	Anatomical Gifts		
H-1088 H-1089 H-1090	Would change the name of the "Anatomical Board of Pennsylvania" to "The Human Gifts Registry"	Support with amendments to make the Board more significant	Passed in the House; Referred to Senate Committee on State Government
	Blood and Laboratories		
H-220	"Pennsylvania Blood Bank Act" — would permit the Department of Health to regulate and license blood banks	Deferred action pending further information	Referred to House Committee on Appropriations
H-1030	Would require all persons working in clinical laboratories to be registered with the Department of Health	Under study	Referred to House Committee on Health and Welfare
H-1266	Would exempt hospitals and blood banks from liability in the transfusion of blood and the transplantation of tissue, bones and organs	Support	On calendar for several weeks — Recommitted to House Judiciary Committee

Bill No.	Explanation	Society's Position	Legislative Position
	Chiropractic		
H-816	Would require insurance companies to pay for the services of chiropractors when that insurance company pays other practitioners for similar services	Oppose	Referred to House Committee on Professional Licensure
H-817	An amendment to the "Chiropractic Practice Act" that would permit the Board to promulgate and enforce rules of "professional conduct appropriate to establish and maintain a high standard of integrity and dignity in the profession of chiropractic."	Oppose	Referred to House Committee on Professional Licensure
H-818	Would amend the "Statutory Construction Act" proposing that the word "physician" include "doctors of chiropractic"	Oppose	Referred to House Committee on Professional Licensure
	Drugs		
H-850	"Pennsylvania Drug, Narcotic and Alcohol Abuse Control Act of 1971" — would set up a Governor's Council to coordinate the efforts of all state agencies	Support	Passed in the House 194-0; Referred to Senate Committee on Public Health and Welfare
H-851	"Drug, Device and Cosmetic Act of 1971" — would bring state law in conformity with new federal law and regulation	Support with proposed amendments concerning telephone prescriptions	Amendments added in the House; passed in the House. Referred to Senate Committee on Public Health and Welfare
H-543	Would amend the "Drug, Device and Cosmetic Act of 1961" to require physicians to prescribe on "check type" pads	Oppose	Referred to House Committee on Health and Welfare
H-923	Would amend the "Pharmacy Act of 1961" to require pharmacists to put name of drug and purpose of use on label	Oppose	Referred to House Committee on Health and Welfare
H-1179	Would authorize the creation of Citizens Advisory Councils on Narcotics in countries, cities, boroughs, townships and incorporated towns, and prescribing the powers and duties of such councils	Under study	Passed House: Referred to Senate Committee on Public Health and Welfare
	Eyeglasses		
H-434	Would set safety standards for eyeglasses, sunglasses and frames sold to the general public — they may not be inflammatory, etc.	Support	In House/Senate Conference Committee
	Fluoridation		
S-716	Would require communities to fluoridate their public water supplies	Support	Referred to Senate Committee on Public Health and Welfare

Bill No.	Explanation	Society's Position	Legislative Position
	Health Insurance		
H-60	"The Voluntary Nonprofit Health Service Act" — permits lay-dominated health services corporations	No opposition if Society's amendments added	On House calendar
H-1138	Would remove requirements from the "Nonprofit Corporation Act" that a majority of the incorporators and members of the Board of Blue Shield be physicians	Oppose	Passed the House; Referred to Committee on Corporations of the Senate
H-872	Would provide for elimination of discriminatory provisions relating to professional compensation for services and treatment under commercial sickness and accident contracts	Opposed following addition of Chiropractic by the Senate	Approved by the Governor on August 12, 1971; Act No. 78
	Hospitals		
S-427	Would set up a "Pennsylvania Hospital Control Commission" made up of three members appointed by the Governor for terms of six years	Oppose	Referred to Senate Committee on Public Health and Welfare
H-600	"The Pennsylvania Health Agency Act" — would set up a "Pennsylvania Health Agency" which is broken down into five additional boards, i.e., "Hospital Control Board", "Health Services Control Board", etc.	Oppose	Referred to House Committee on Consumer Protection
H-931	Would abolish State general hospitals as such, and provide for the community to take them over	Support	Referred to House Committee on Health and Welfare
	Hypnotism		
S-638	Would create a Board to license hypnotists and provide certain regulations and control for those practicing hypnotism	Oppose	Passed Senate; referred to Committee on Professional Licensure
	Liability		
S-265	Would relieve physicians, hospitals and their employees from liability in certain cases involving emergency treatment procedures and operations to minors	Support	Referred to Judiciary Committee of the Senate
S-447	Would exempt physicians and nurses from liability when participating in mass immunization projects approved by the Pennsylvania Department of Health	Support	Passed in the Senate; Referred to the House Judiciary Committee
S-528	Would amend the "Disease Prevention and Control Law of 1955" to provide that any person under twenty-one may be treated for veneral disease by a physician without the consent of the minor's parents for which the "physician shall not be sued or held liable for properly administering appropriate treatment to the minor"	Support	Passed Senate; referred to Committee on Health and Welfare of the House

Bill No.	Explanation	Society's Position	Legislative Position
	Local Health Departments		
H-990	The revised "Local Administration Law"	Under study	Referred to Senate Committee on Public Health and Welfare
	Malpractice		
S-851	An act relating to the settlement or release of liability for personal injury or property damage; and prohibiting releases and solicitation of releases in hospitals	Support (bill amended in Senate to prohibit attorneys' contingency fees)	Passed the Senate; Referred to Judiciary Committee in the House
	Medical Examiner		
H-716	Would abolish all offices of Coroner in the state and authorize Department of Health to divide the Commonwealth into regions for the purpose of establishing regional centers and Medical Examiners in those regions	Support in principle	Referred to House Committee on Local Government
S-751	An act relating to optional plans of government for Pennsylvania municipalities permitting county government to move to Medical Examiners	Support with Society's suggested amendments to permit Medical Examiners	Referred to Senate Committee on Local Government
S-752	An act relating to home rule charters for municipalities	Support—same as above	Referred to Senate Committee on Local Government
	Mental Health		
S-636	Would give certain rights to treatment to mental patients in mental institutions, and sets up hearing mechanisms and remedies for patients in mental institutions	No formal action taken because of lack of information	Referred to Senate Committee on Public Health and Welfare
H-720	"Right to Treatment Law of 1971" (Similar to S-636)	No formal action taken because of lack of information	Referred to House Committee on Health and Welfare
H-721	"Institutional Peonage Abolishment Act"	Same as above	Referred to House Committee on Health and Welfare
H-1145	Would repeal the section of the "Welfare Code" creating the office of the Commissioner of Mental Health	Oppose	On second consideration in the House
H-1184	Would amend the "Mental Health and Mental Retardation Act of 1966" to remove the requirement that Directors of state mental facilities be physicians	Oppose	Passed in the House; referred to Senate Committee on Public Health and Welfare

Bill No.	Explanation	Society's Position	Legislative Position
	Motor Vehicles		
H-1012	Would amend "The Vehicle Code" requiring physicians to notify the Secretary when they gain certain information through an examination	Opposed unless physicians are given legal protection	Referred to House Committee on Transportation Safety
	Nursing		
H-967	Would change the make-up and increase the size of the State Board of Nursing	Support	Referred to House Committee on Professional Licensure
H-968	Would change certain definitions and the responsibilities of the State Board of Nursing	Support, except the nurses should eliminate the licensing of para-nursing disciplines concept	Referred to House Committee on Professional Licensure
	Osteopathy		
H-442	Would amend the "Medical Practice Act" to permit osteopaths to apply for examination and licensure	Oppose	Referred to House Committee on Professional Licensure
H-433	Would amend the "Osteopathic Practice Act" to permit physicians to apply for examination and licensure	Oppose	Referred to House Committee on Professional Licensure
	Physicians' Assistants		
H-414	An amendment to the "Medical Practice Act" to permit the Board of Medical Education and Licensure to regulate the training of physicians' assistants.	Oppose	Referred to House Committee on Professional Licensure
	Safety Glass in Doors		
S-29	Would require the use of safety glazing materials in hazardous locations in residential, commercial and public buildings	Support	Approved by the Governor on June 2, 1971; now Act No. 5
	TB Testing		
H-433	Would amend the "Public School Code of 1949" removing X-ray testing for TB and permitting tests prescribed by the Secretary of Health for teachers, school employees and certain other persons	Support	Signed by the Governor; now Act No. 47

Bill No.	Explanation	Society's Position	Legislative Position
	Welfare Medical Programs		
H-794	Defines "levels of care" in nursing homes, homes for the aged and infirm, and in boarding homes. The measure puts back into the Department of Public Welfare some of the "muscle" needed to enforce regulations for boarding facilities	Under study; defer action until further information	Referred to House Committee on Health and Welfare
H-795	Would amend the Welfare Code to give the Auditor General more authority in certifying to the cost of nursing home care	Same as above	Referred to House Committee on Health and Welfare

Appendix I

September 22, 1971

TO: PMS House of Delegates
Presidents and Executive Secretaries - County Medical Societies
Presidents and Secretaries - Specialty Societies
Presidents - Hospital Medical Staffs

RE: Department of Public Welfare - Medical Assistance Program

Gentlemen:

During the past several months the Pennsylvania Medical Society has received many inquiries from county medical societies, hospital medical staffs, specialty societies, and individual members regarding recent changes in the administration of the Commonwealth's Medical Assistance Program, particularly the promulgation of MA Memorandum No. 16, which requires a review of all MA admissions within seventy-two hours and the completion of a cumbersome check list.

In view of the fact many of the Pennsylvania Medical Society's recommendations to improve the MA Program have not been accepted by the Department of Public Welfare, a meeting with the Secretary of DPW was requested on June 21, 1971. After some delay, a meeting with the Secretary and representatives of the Society was held on August 25, 1971.

During the August 25, 1971 meeting, representatives of the Society presented three proposals which are outlined in the attached letter sent to the Secretary on August 26, 1971. While these recommendations will not solve many of the problems related to the administration of the Medical Assistance Program, it was felt they would serve as a reasonable basis for developing constructive solutions. Although the Society's representatives were promised a prompt reply during the meeting, a response has not been received to date.

The Medical Assistance Program is one of the important issues that will be discussed by the 1971 PMS House of Delegates at its Annual Meeting the first week of October in Pittsburgh. The Reference Committee on Medical Service - Section A will consider several resolutions and recommendations related to the Medical Assistance Program at its open hearing on Tuesday morning, October 5, at the Pittsburgh Hilton.

We would appreciate any comments or recommendations you may have to guide the House of Delegates in establishing its position related to the Medical Assistance Program.

Thank you for giving this request your consideration.

Sincerely yours,
William A. Limberger, M.D.
President

August 26, 1971

The Honorable Helene Wohlgemuth
Secretary
Department of Public Welfare
Commonwealth of Pennsylvania
333 Health and Welfare Building
Harrisburg, Pennsylvania 17120

My dear Mrs. Wohlgemuth:

I am writing to follow up our discussion of the Commonwealth's Medical Assistance Program during our meeting in your office yesterday afternoon. I was pleased to have the opportunity to personally discuss our mutual problems with you. We felt the meeting was productive and I am hopeful we can maintain "open" communications as we seek solutions to the problems of financing the Medical Assistance Program and delivering medical services to the disadvantaged citizens of our Commonwealth.

In accordance with your request, I am summarizing for your consideration the following recommendations of our Society which were presented at the meeting:

I. *Medical Assistance Memorandum No. 16* — Utilization and Review of Hospital Services

As we pointed out during our meeting, the Pennsylvania Medical Society was a pioneer in developing and implementing the utilization review concept. Our activities over the past fourteen years indicate that physicians in Pennsylvania are strongly committed to the concept of utilization review as a means of assuring efficient use of our hospital facilities. Any requirement that mandates a hospital to develop more than one utilization review plan results in additional expense to the hospital and requires a considerable amount of unnecessary work for the medical staff. We believe that all hospitals should have a functioning

utilization review plan which is uniform to assure that the health care received by all patients is judged by the same standards. We feel that the hospital utilization review regulations for the Medical Assistance Program should reflect a similar policy. Accordingly, we recommend that the provision in MA Memorandum No. 16, requiring a review of all admissions within seventy-two (72) hours and the completion of a check-off form, be deleted from the present regulations. There has been no indication, in our experience, that either of these requirements will improve the utilization of hospital facilities to justify the increased expense and unnecessary use of a physician's time.

However, at the same time, we recognize that there are a small number of physicians who have unusual utilization patterns and that there are certain hospitals that do not have effective utilization review programs. We urge your department to document these situations and bring them to our attention so that we may assist you in resolving these individual problems. We also offer you the services of our Society's Council on Medical Service to assist you in developing more effective hospital utilization review regulations.

II. *Pilot Project*

During the meeting we discussed the fact that certain provisions in the present Medical Assistance Regulations have a tendency to foster over-utilization of in-hospital facilities. It is our feeling that if the benefit structure of a health insurance program provides benefits that are comparable to the manner medical care is delivered, more effective cost control mechanisms can be built into the program reducing the need for cumbersome regulations. Therefore, we recommend the development of a pilot project to test the validity of this concept as it would apply to the MA Program. We would envision that payments under such a pilot project would be based on usual, customary, and reasonable fees with a realistic benefit structure with the necessary cost controls. We believe that the cost control techniques presently being developed by the Pennsylvania Medical Society's Medical Care Appraisal Project could be implemented in such a pilot program. I am enclosing a copy of Excerpts from the Society's Grant Application for an Experimental Medical Care Review Organization, which was recently approved by the U.S. Department of HEW's National Center for Health Services Research and Development. The various cost control mechanisms which are essential in a health care program are outlined in these Excerpts.

III. *Ad Hoc Committee to Review Medical Assistance Regulations*

We believe that the appointment of a small Ad Hoc Committee to study the many problems related to the Medical Assistance Program could perform a vital service to improve the present administration and benefit structure of the MA Program. We recommend that such an Ad Hoc Committee be appointed and be responsible to your office. The Committee could be made up of representatives of the following groups: Pennsylvania Medical Society; Pennsylvania Osteopathic Medical Association; Keystone Medical Society; Hospital Association of Pennsylvania; Pennsylvania Department of Public Welfare; and medical assistance recipients.

In conclusion, I would like to stress the point that the Pennsylvania Medical Society supports the basic objective of your department's Medical Assistance Program, i.e., delivery of high quality medical care at a reasonable cost to the disadvantaged citizens of the Commonwealth. We believe that the adoption of the above recommendations will serve as a basis for improving the present MA Program. It is our desire to encourage physicians in Pennsylvania to provide medical care for MA recipients, although this position is sometimes difficult to support in view of the present problems. Since the Pennsylvania Medical Society's House of Delegates will be holding its annual meeting during the first week of October, it is of vital importance that we receive your reaction to our recommendations by the middle of September.

We look forward to cooperative efforts with your department in achieving our mutual objectives.

We anxiously await your reply. Thank you for giving our recommendations your consideration.

Sincerely yours,
William A. Limberger, M.D.
President

Appendix J
Supplemental Report B
Board of Trustees

At its meeting on October 3, the Board of Trustees took several actions which are of interest to the House of Delegates or require further action by the House

Referred to Reference Committee on Constitution and Bylaws

The Board of Trustees reviewed a recommendation by the Speaker of the House of Delegates concerning a recommended change in the Bylaws which would permit the Speaker to appoint such reference committees as he deemed necessary to expedite the business of the House rather than be limited to the number or categorical names for reference committees as currently provided for in the Bylaws. The Board of Trustees supports the Speaker's recommendation and commends it to the House of Delegates for its consideration and action. The following is the actual language which would implement the proposed change:

BYLAWS, CHAPTER III. —
HOUSE OF DELEGATES, SECTION 9 —
REFERENCE COMMITTEES

"The Reference Committees of the House of Delegates shall each consist of five members whose terms shall end the following May 31, appointed annually by the Speaker of the House of Delegates prior to August 1 from among the then certified voting delegates. [, and shall be as follows:

Committee on Reports of Officers
Committee on Reports of Standing and Special Committees
Committee on Education and Science
Committee on Governmental Relations
Committee on Public Service
Committee on Medical Service
Committee on Miscellaneous Business]

The Speaker shall appoint such Reference Committees and clearly identify them as he deems necessary to expedite the business of the House.

"In addition to the foregoing, the Standing Committee on Constitution and Bylaws shall be a Reference Committee of the House of Delegates. Each member of the Society has a right to appear and be heard before any reference committee of the House of Delegates.

"Each report, resolution and proposition presented to the House of Delegates shall be referred for consideration and report to one or more of the reference committees, as may be appropriate, and as the Speaker of the House of Delegates shall determine. The reports of the reference committees shall be presented to the House of Delegates before final action may be taken unless otherwise ordered by the House of Delegates by a two-thirds vote of those present and voting."

(Brackets signify material that should be deleted; italics signify new language).

Referred to Reference Committee on Education and Science

The Board of Trustees also reviewed a request from the Pennsylvania Division of the American Cancer Society with regard to its goal proposing that every woman in the United States have a Pap test for cancer of the cervix by 1976. The Pennsylvania Division asks for the support and cooperation of the Pennsylvania Medical Society in principle for this national goal. The Board of Trustees strongly endorses the Cancer Society's objective and urges the House of Delegates to adopt a similar position.

The Board takes this opportunity to report the following actions for the information of the House:

Referred to Reference Committee on Education and Science

1. Determined that the Society should continue to cosponsor in Pennsylvania the medical education community orientation program by the Student American Medical Association.

Referred to Reference Committee on Education and Science

2. Adopted a plan to urge physicians to limit the prescription of amphetamines and other stimulant drugs to specific, well recognized, medical indications.

Referred to Reference Committee on Medical Service A

3. Determined to urge Blue Cross to expand the pre-admission testing program with Pennsylvania Blue Shield as a participant so that pre-admission studies may be conducted in an out-patient facility of a hospital or a physician's private office or laboratory.

Referred to Reference Committee on Medical Service A

4. Reiterated its support of the prevailing fee concept and determined to urge Pennsylvania Blue Shield to actively market the prevailing fee program. Resolved to recommend that Blue Shield continue its original efforts to revise Plan B in accordance with previous recommendations approved by the Board (for further information see Supplemental Report A of the Council on Medical Service).

Referred to Reference Committee on Medical Service B

5. Approved Supplemental Report B of the Council on Medical Service which outlines a series of systems to develop the Pennsylvania Medical Care Foundation.

Referred to Reference Committee on Medical Service A

6. Named the law firm of Pepper, Hamilton and Scheetz as chief defense counsel for the Society's professional liability insurance program.

Referred to Reference Committee on Public Service

7. Authorized the Council on Public Service to inquire informally into the availability of funds for establishing mobile health care units for rural areas in Pennsylvania.

Referred to Reference Committee on Education and Science

8. Adopted a position statement concerning the production of health professionals developed by the Pennsylvania Medical Society and the Deans of Schools of Medicine in Pennsylvania. The statement is as follows:

"The demands upon Schools of Medicine for greater involvement to improve health care delivery and to increase manpower come at a time when the schools of medicine are faced with great financial problems. Medical education has always been the costliest component of higher education. These costs have been aggravated by inflation and the higher expense of teaching modern medicine. Furthermore, there have been serious decreases in federal support of medical research and in private sources of support which have caused financial instability in medical education. To permit the schools of medicine in the Commonwealth to produce more physicians and to provide necessary services, we must recognize that Pennsylvania Medical Schools are public resources which must receive adequate and continuing public and private support.

"The following position statement is a commitment of the Schools of Medicine in Pennsylvania and the Pennsylvania Medical Society to a plan of action to expand the supply of health professionals in the Commonwealth.

1. *Joint Objectives*

We are determined to improve health care services in the Commonwealth by:

A. Improved access to health care professionals in all areas of the State, including remote rural districts and center cities.

B. Expansion and improved utilization of educational facilities to produce more health professionals.

C. Cooperation with the Department of Education in developing an equitable formula in the State Master Plan for Higher Education which in harmony with federal assistance will provide adequate, equitable, and continuing financial support to medical schools in the Commonwealth.

D. Specific proposal for funding to the Legislature calling for:

(1) *Capitation grants* for medical and other health science students based on a formula which includes a built-in inflation factor.

(2) *Special program grants* to implement educational and research activities.

(3) *Capital grants* for the expansion of resources in existing medical schools.

2. *School Objectives*
Schools of Medicine will:

A. Seek to improve the delivery of health services by greater participation in community affairs.

B. Plan curricula that will direct students into primary medicine and specialties where the current needs exist and graduate them in the shortest possible time consistent with quality.

C. Utilize more fully the existing higher education and hospital resources of the Commonwealth through innovative programs to increase the production of needed health professionals.

3. *Society's Objectives*
The Pennsylvania Medical Society will:

A. Undertake federal and state lobbying efforts for financial support of the medical schools in Pennsylvania.

B. Conduct a state-wide public information program to stimulate support for medical education.

C. Expand through the Educational and Scientific Trust of the Society its loan program to medical students.

D. Continue to seek better distribution of physicians to remote rural and core urban areas of the Commonwealth through its Physician Placement Service, and the use of a federal mechanism to practice in a place where medical manpower is needed as an alternative to military service."

Appendix K
Woman's Auxiliary to the Pennsylvania Medical Society
Report of the President

Dr. Limberger, Dr. Rial, officers, members and guests of the Pennsylvania Medical Society's House of Delegates:

The Woman's Auxiliary to the Pennsylvania Medical Society is grateful for this opportunity to report to you the accomplishments of the State Auxiliary and its fifty-seven active county auxiliaries for 1970-1971.

Presently 5,515 physicians' wives are members of the Auxiliary. Pennsylvania would be nearer its 100 percent potential if we gained an additional 5,000 members. Membership-wise, we are still third in the nation; California and Texas being first and second and Ohio a very close fourth! Each county has been encouraged to move membership by 10 percent over the previous year. Recognition for this achievement will be made at this convention by awarding membership citations to six counties.

Our State Auxiliary is divided into three regions, twelve councilor districts and fifty-seven organized and five unorganized counties. Three regional workshops were held in October, 1970, and Mid-Year Conference was held in April, 1971.

The five priority projects presented at state regional workshop sessions were AMA-ERF, Community Health, Health Careers, Legislation and Membership. Presidential visits were made to fifty county auxiliaries this year. A message was presented on the meaning of "Medical Auxiliary Membership," stressing active participation of each member in the community health picture. Reports have been received from forty-nine counties, showing participation in one or more of the priority projects or in projects related to individual community needs.

Three important funds have received our contributions. To the American Medical Association Education and Research Foundation, we have given $6,757.64; to the Educational and Scientific Trust Fund of the Pennsylvania Medical Society in 1970, $4,377.18; and to the Medical Benevolence Fund in 1970, $7,798.93.

This year the "Auxiliary Health Careers Financial Aid Fund" within the Educational and Scientific Trust of the Pennsylvania Medical Society has been established. The growing need for well trained personnel in health careers is apparent in every community. This Fund will aid applicants for allied health career scholarship loans. Contributions in lieu of gifts from the counties for the president have advanced the fund to $4,174.91 this first year. Eventually, this project will be a very real and vital Auxiliary activity.

Health Careers is our number one project throughout the state. County auxiliaries have reported the presentation of sixty Health Career Assembly programs, thirty-five Hospital Tours and Health Career Day programs. To date, this has resulted in the establishment of forty-nine "Careers in Health" clubs. Twenty-eight counties offered seventy-one Scholarship Grants, totaling $21,442. Thirteen counties offered loans in the amount of $15,923. We were proud to learn that the State Auxiliary Health Careers chairman has written an article on 'Health Careers — Health Manpower" to be published in the November issue of PENNSYLVANIA MEDICINE.

Home-Centered Health Care programs received increased Auxiliary interest and activity. Seventeen counties reported "Home-Centered Health Care" service projects. Fund-raising projects for "Homemaker - Home Health Aide" service were successful for many counties. Since establishing such service is prohibitive for auxiliaries, financial support of existing agencies is always welcome. Seven counties engaged in "Meals Service" and Volunteer Friendly Visitor Programs.

International Health Activities continue our outreach to people: missions have received an increased volume of medical and surgical supplies; foreign doctors and their wives have been welcomed and aided; doctors' families have housed exchange students; two International Days were held; two counties compiled lists of people with special language abilities to serve as interpreters when needed; several counties had Doctor-to-Doctor Contacts in foreign countries; financial assistance has been continued to a Korean student, Miss Kyoung Sook Suk, for her education in rehabilitation of the blind.

Highway Safety was studied and several counties participated in defensive driving courses. One county had forty-

four members certified as defensive drivers. The Auxiliary had representation at the "Forum on Traffic Safety Alcohol Countermeasures" for Womens' National Organizations held in Washington, D.C. The Forum was presented by the U.S. Department of Transportation and the National Highway Traffic Safety Administration. Auxiliary members have written letters to legislators urging passage of legislation to improve highway safety. The Mid-Year Conference theme in April was "Everybody's Problem - Alcohol in Relation to Highway Safety". A panel discussion on this topic was presented followed by showing of the film, "The Drinking Driver."

The State Chairman of Children and Youth served as a delegate to the "White House Conference on Children." She presented an excellent report to the membership at Mid-Year Conference. Twenty-eight counties were active in projects that included: hearing and visual screening tests; symposiums on emotional problems of children; a panel presentation on "A New Look At Health, Education and Justice Systems for Children"; sex education and venereal disease programs; measles immunization programs; health examinations for day care centers; teaching GEMS courses; drug abuse educational programs including poster contests; an "LSD Ball" (Lets Stop Drugs) with profits contributed to a drug rehabilitation center and a first-aid room in "Gaudenzia House" furnished by a county auxiliary.

The legislative emphasis this year has been on PaMPAC and AMPAC Memberships and on the AMA proposed Medicredit Bill. Current legislative activities were reported by county chairmen at Auxiliary meetings. Thirty-two counties took part in an organized visit to the State Legislature. We were honored to have our State Legislative Chairman elected to serve on the PaMPAC Board of Directors.

The celebration of Doctors' Day on March 30 has extended to many county auxiliaries across the state. Gifts of medical books and *Today's Health* magazine to hospitals, schools, and public libraries in honor of local physicians served as good public relations. Doctors' Day was observed in an unique way by one county. The Auxiliary arranged for a complete physical examination for their physician husbands during April and May. Would you believe ninety percent of the physicians participated!

The Auxiliary had representation on the Pennsylvania Health Council and Community Services of Pennsylvania. We have a liaison to the Woman's Auxiliary to the Student American Medical Association. There are seventy WA/SAMA Chapters in the United States, ten chapters in Pennsylvania, "More Members — More Involved" is the theme of the newly elected president, Mrs. Jerrald Kuenn from York. Under her leadership, WA/SAMA will continue to become involved and move ahead.

The Pennsylvania Society, American Association of Medical Assistants is a very active group. Their Annual Convention held in Pittsburgh in May was outstanding in content and enthusiasm. We had the honor of attending, learning to know the members, and addressing the House of Delegates. Since our goals and objectives are similiar, we should work together to maintain good public relations between physicians, patients and the community.

The president, plus our full complement of seventeen delegates, attended the Annual Convention of the Woman's Auxiliary to the AMA held in Atlantic City, June 20 to 23, 1971. We were honored to have Mrs. Robert F. Beckley, a past state president from Clinton County, installed as president-elect of the Woman's Auxiliary to the AMA. When Mrs. Beckley is installed as President in June, 1972, Pennsylvania will lead the nation, holding the record of six national presidents.

We appreciate the privilege of repesenting the State Auxiliary at meetings of the councils on public service; governmental relations; education and science and the annual officers' conference. Because of this orientation on the problems facing medicine today, we are able, as your Auxiliary, to translate this need into positive action.

Our thanks to Dr. J. Thomas Millington and his advisory committee and to the Society's very able staff members for their invaluable assistance and guidance. My sincere gratitude to Dr. William A. Limberger and the officers of the Society for their cooperation and encouragement in every Auxiliary effort.

Without our capable executive secretary, Arlene C. Oyler, it would be impossible to carry on Auxiliary business as efficiently as we do. For her continued help, understanding and dedication to the Auxiliary, we are grateful.

Through my message tonight, I hope once again to have impressed you with the many accomplishments of the Doctors' Wives — Your Wives — Your Auxiliary. They have set definite goals and achieved them. They have truly been "Active Health Leaders During These Changing Times." There is NO LIMIT to what the Auxiliary can do with your encouragement and direction, as we work together toward better health for all Americans, and indeed for all mankind.

Appendix L
Committee to Nominate
Delegates and Alternates to the AMA

Nominations for two-year terms commencing January 1, 1972, for delegates to succeed themselves:

John B. Lovette, M.D., Cambria County; age 50. AMA activities: Alternate delegate - five years; delegate - two years. Attended all sessions. Attended all assigned reference committee hearings.

Malcolm W. Miller, M.D., Philadelphia County; age 63. AMA activities: Alternate delegate - three years; delegate - five years; reference committee member; regular attendance; routine assignments. Prior to the presently expiring two-year term, served in substituting for someone else when an alternate. Also at times when Pennsylvania was due for an additional delegate, was appointed by the Board of Trustees to serve.

Russell B. Roth, M.D., Erie County; age 57. AMA activities: Alternate delegate - two years; delegate - eight years; reference committee member; regular attendance; routine assignments; for three years, served as Vice Speaker of the AMA House; serving third term as Speaker of the AMA House; served on Council on Medical Service, Federal Medical Services; Ad Hoc Liaison with Council on Medical Education and Hospitals; Liaison Committee of Council on Medical Education and the Council on Medical Service. Member, AMA Commission on Cost of Medical Care.

Nominated by AMA and subsequently appointed to National Advisory Council on Regional Medical Programs. Serves as member of Special Medical Advisory Group to the Veterans Administration and of Steering Committee on Experimental Medical Care Review Organizations in HEW. Has given AMA testimony before Congressional committees on six occasions.

Nominations for two-year terms commencing January 1, 1972, for delegates who are currently alternates:

Paul S. Friedman, M.D., Philadelphia County; age 57. AMA activities: Alternate delegate - three years; current member of Council on Legislation; attended conventions and caucuses; represented delegation at hearings of reference committees. Member National Speakers Bureau.

Matthew Marshall, Jr., M.D., Allegheny County; age 50. AMA activities: Alternate delegate - three years; served as teller one year; attended reference committee hearings.

Nominations for two-year terms commencing January 1, 1972, for alternate delegates:

Robert F. Beckley, M.D., Clinton County; age 55. AMA activities: Current alternate, elected in October 1970; attended both sessions of the House of Delegates and spoke to PMS positions at reference committees and with other state delegates. Assisted in PMS hospitality suite. Attended some of the meetings of Woman's Auxiliary to the AMA and was privileged to entertain some of their officers.

Robert J. Carroll, M.D., Allegheny County; age 47. As a member of the Allegheny County Medical Society served as President, 1969; Chairman of the Board, 1970; member, Board of Directors - 1954 to 1963 and 1967 to date; Chairman, Health Services Planning Committee - 1970 to date; School and Child Health Committee - 1965 to date; delegate to PMS House - 1968 to date. PMS activities: Committee on Objectives - 1970 to date; Council on Governmental Relations - 1971; Board of Pennsylvania Medical Political Action Committee - 1971.

Wilbur E. Flannery, M.D., Lawrence County; age, 64. AMA activities: Current alternate, serving six years; attended all but three sessions. Took assignments at each meeting which were made by chairman of delegation to attend and report on meetings of reference committees. On four occasions acted as delegate when either the regular delegate could not attend or had to leave the session before adjournment. Participated in discussions at reference committee meetings and on the floor of the House of Delegates when acting as a delegate.

John Helwig, Jr., M.D., Philadelphia County; age 44. As a member of the Philadelphia County Medical Society served on Board of Censors; Board of Directors; Medical-Legal Affairs; Grievance and Professional Relations; Heart and Circulating Disease; Delegate to PMS House - five years. PMS activities: Council on Medical Service, three years; Commission on Professional Liability Insurance.

William J. Kelly, M.D., Allegheny County; age 49. As a member of the Allegheny County Medical Society served as Secretary; First Vice President; Board of Directors; President-Elect; President; Parliamentarian; Committees on Hospital and Professional Relations; Medical-Legal Committee. Delegate to PMS House - twelve years. PMS activities: Member Board of Trustees, four years; Committees on Constitution and Bylaws, three years; Discipline, four years; Finance, two years; Review Medical Practice Act, two years; Council on Governmental Relations, three years; Publication, one year; Benjamin Rush Awards, four years. PMS Board representative to the State Board of Medical Education and Licensure since May, 1969.

David S. Masland, M.D., Cumberland County; age 48. AMA activities: Current alternate, serving six years. Attended all caucuses and meetings of the delegation over the past two years. Served as delegate at the Clinical Session in Boston being appointed by the chairman to replace a physician who was unable to attend. Served as a member of a reference committee.

Robert S. Sanford, M.D., Tioga County; age 51. As a member of the Tioga County Medical Society served as Secretary-Treasurer nine years; President, 1954; Committees on Blue Cross-Blue Shield, eight years; Public Relations, one year; Rural Health, one year; Legislation, one year; Medicine and Religion, four years. Delegate to PMS House - sixteen years. PMS activities: Board of Trustees, nine years; Committees on Benjamin Rush Awards, one year; Aid to Education, six years; Publication, six years; Medicine and Religion, eight years; Susquehanna Valley Regional Medical Program, five years; Council on Medical Service, four years; Second Vice-President, one year.

SPEAKER RIAL

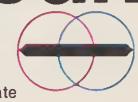
VICE-SPEAKER LOVETTE

psychic stress and somatic symptoms

The intertwining of psychic stress and somatic symptoms often confuses and distorts the patient's clinical profile. Sinequan (doxepin HCl) can help clarify the origin of somatic symptoms by relieving the causative, or accompanying, psychoneurotic anxiety and depression.

Sinequan®
DOXEPIN HCl

Starting dosage:
25 mg. t.i.d.
for mild to moderate
symptomatology



The tranquilizer that is an antidepressant. The antidepressant that is a tranquilizer.

BRIEF SUMMARY

Sinequan (doxepin HCl) **Capsules**

Contraindications. Sinequan (doxepin HCl) is contraindicated in individuals who have shown hypersensitivity to the drug.

Sinequan (doxepin HCl) is contraindicated in patients with glaucoma or a tendency to urinary retention.

Warnings. *Usage in Pregnancy:* Sinequan (doxepin HCl) has not been studied in the pregnant patient. It should not be used in pregnant women unless, in the judgment of the physician, it is essential for the welfare of the patient, although animal reproductive studies have not resulted in any teratogenic effects.

Usage in Children: The use of Sinequan (doxepin HCl) in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors: Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with Sinequan (doxepin HCl). The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

Precautions. Since drowsiness may occur with the use of this drug, patients should be warned of that possibility and cautioned against driving a car or operating dangerous machinery while taking this drug.

Patients should also be cautioned that their response to alcohol may be potentiated.

Since suicide is an inherent risk in any depressed patient and may remain so until significant improvement has occurred, patients should be closely supervised during the early course of therapy.

Although Sinequan (doxepin HCl) has significant tranquilizing activity, the possibility of activation of psychotic symptoms should be kept in mind.

Other structurally related psychotherapeutic agents (e.g., iminodibenzyls and dibenzocycloheptenes) are capable of blocking the effects of guanethidine and similarly acting compounds in both the animal and man. Sinequan (doxepin HCl), however, does not show this effect in animals. At the usual clinical dosage, 75 to 150 mg. per day, Sinequan (doxepin HCl) can be given concomitantly with guanethidine and related compounds without blocking the antihypertensive effect. At doses of 300 mg. per day or above, Sinequan (doxepin HCl) does exert a significant blocking effect. In addition, Sinequan (doxepin HCl) was similar to the other structurally related psychotherapeutic agents as regards its ability to potentiate norepinephrine response in the animal. However, in the human this effect was not seen. This is in agreement with the low incidence of the side effect of tachycardia seen clinically.

Adverse Reactions. *Anticholinergic Effects:* Dry mouth, blurred vision, and constipation have been reported. They are usually mild, and often subside with continued therapy or reduction of dose.

Central Nervous System Effects: Drowsiness has been observed. This usually occurs early in the course of treatment, and tends to disappear as therapy is continued.

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported side effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

Dosage. For most patients with illness of mild to moderate severity, a starting dose of 25 mg. t.i.d. is recommended. Dosage may subsequently be increased or decreased at appropriate intervals and according to individual response. The usual optimum dose range is 75 mg./day to 150 mg./day.

In more severely ill patients an initial dose of 50 mg. t.i.d. may be required with subsequent gradual increase to 300 mg./day if necessary. Additional therapeutic effect is rarely to be obtained by exceeding a dose of 300 mg./day.

In patients with very mild symptomatology or emotional symptoms accompanying organic disease, lower doses may suffice. Some of these patients have been controlled on doses as low as 25-50 mg./day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

Supply. Sinequan (doxepin HCl) is available as capsules containing doxepin HCl equivalent to 10 mg., 25 mg., and 50 mg. of doxepin in bottles of 100; and 25 mg. and 50 mg. in bottles of 1000.

More detailed professional information available on request.

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PFIZER INC., NEW YORK, N.Y. 10017

When disease is ruled out and psychic tension is implicated

Valium® (diazepam) 2-mg, 5-mg, 10-mg tablets

helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose™ packages of 1000.

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